PRINTED: 02/22/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495246 B. WING 02/07/2019 CODE

			***************************************	J 5			
NA	ME OF P	ROVIDER OR SUPPLIER			Sī	REET ADDRESS, CITY, STATE, ZIP CODE	_
we	OODMO	ONT CENTER			11	DAIRY LANE	
27		OLIVIER			FF	REDERICKSBURG, VA 22405	
P	X4) ID REFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THI		
E	SS=B	Corrections are require CFR Part 483.73, Req Care Facilities. EP Training Program CFR(s): 483.73(d)(1) (1) Training program. I ASCs, PACE organizate and dialysis facilities] in (i) Initial training in emergicies and procedures staff, individuals providiarrangement, and volune expected role. (ii) Provide emergency least annually. (iii) Maintain documents (iv) Demonstrate staff k procedures. *[For Hospitals at §482. at §491.12:] (1) Training or RHC/FQHC] must do (i) Initial training in emergicities and procedures staff, individuals providinarrangement, and volune expected roles.	2/5/19 through 2/7/19. ad for compliance with 42 uirement for Long-Term The [facility, except CAHs, ions, PRTFs, Hospices, nust do all of the following: argency preparedness to all new and existing ing services under inteers, consistent with their preparedness training at atton of the training. Inowledge of emergency 15(d) and RHCs/FQHCs program. The [Hospital all of the following: regency preparedness	EO	000	Preparation and/or execution of this Correction does not constitute admir agreement of the provider of the tru alleged or conclusions set forth in the deficiencies. The Plan of Correction is and/or executed solely because it is reprovisions of federal and state law. 1. The 3 out of 113 employees had not completed Emergen Preparedness Training (EPP) training will be completed as 3/1/2019. 2. All residents at risk for staff is trained. 3. All new employees will receive EPP training during new employee orientation. All current employees will compute Annual training with our annual corporate compliance training by October 2019. 4. Audits of Training log will be monitored monthly by CED. Audits will be reviewed at Quality Assurance and Performance Improvement Committee monthly with QA	who so of not ive
	(iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures.				committee responsible for ongoing compliance.		
/	1	[For Hospices at §418.	l13(d):] (1) Training. The			5. Date of Compliance: 3/13/20	

cution of this Plan of stitute admission or ler of the truth of the facts et forth in the statement of Correction is prepared ecause it is required by the state law.

- employees who ed Emergency aining (EPP) ompleted as of
- isk for staff not
- es will receive ng new ation. All es will complete ng with our compliance er 2019.
- g log will be hly by CED. riewed at e and provement thly with QAPI nsible for nce.
- nce: 3/15/2019

(X5) COMPLETION

DATE

LATORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

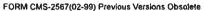
TITLE

(X6) DATE

Any desciency statement and ling with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide difficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495246	B. WING			1	07/2019
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405			•	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	""		(X5) COMPLETION DATE	
E 037	policies and proced hospice employees services under arra expected roles. (ii) Demonstrate staprocedures. (iii) Provide emerge least annually. (iv) Periodically revemergency prepare employees (includispecial emphasis procedures necessothers. *[For PRTFs at §44 program. The PRT (i) Initial training in policies and procedures arrangement, and expected roles. (ii) After initial train preparedness train (iii) Demonstrate staprocedures. (iv) Maintain documpreparedness train (iv) Maintain documpreparedness train (iv) Initial training in policies and procedures and proce	of the following: emergency preparedness dures to all new and existing and individuals providing ungement, consistent with their aff knowledge of emergency ency preparedness training at eliew and rehearse its edness plan with hospice and nonemployee staff), with elaced on carrying out the arry to protect patients and ency preparedness dures to all of the following: emergency preparedness dures to all new and existing oviding services under volunteers, consistent with their ency, provide emergency ing at least annually. aff knowledge of emergency	E	037			





Facility ID: VA0279

If continuation sheet Page 2 of 206



DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/22/2019 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING_ COMPLETED 495246 B. WING NAME OF PROVIDER OR SUPPLIER 02/07/2019 STREET ADDRESS, CITY, STATE, ZIP CODE **WOODMONT CENTER** 11 DAIRY LANE FREDERICKSBURG, VA 22405 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (X5) COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) E 037 Continued From page 2 E 037 (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster

authorities, to all new and existing staff,

individuals providing services under arrangement, and volunteers, consistent with their expected

PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		TE SURVEY
		495246	B. WING			C)2/07/2019
	ROVIDER OR SUPPLIER		Ì	STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
E 037	least annually. (iii) Maintain docur (iv) Demonstrate s procedures. *[For CMHCs at §4 CMHC must provice preparedness police and existing staff, under arrangemen with their expected documentation of the demonstrate staff is procedures. There emergency prepare annually. This REQUIREME by: Based on staff inter review it was deter have a complete en The facility staff fait documentation of the preparedness train CNA (certified nurs and CNA #14. The findings include On 2/7/19 at 11:12 the facility's emergical conducted with oth maintenance direct emergency prepared	ency preparedness training at mentation of the training. taff knowledge of emergency (85.920(d):] (1) Training. The le initial training in emergency sies and procedures to all new individuals providing services t, and volunteers, consistent croles, and maintain the training. The CMHC must knowledge of emergency after, the CMHC must provide edness training at least. NT is not met as evidenced erview and facility document mined the facility staff failed to mergency preparedness plan. Ided to provide evidence of the facility's initial emergency ing for three of 113 employees, ing assistant) #12, CNA #13,	€ 033			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y3OC17

Facility ID: VA0279

If continuation sheet Page 4 of 206



DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 02/22/201 STATEMENT OF DEFICIENCIES FORM APPROVE (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-039 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING_ COMPLETED 495246 NAME OF PROVIDER OR SUPPLIER B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 02/07/2019 **WOODMONT CENTER** 11 DAIRY LANE FREDERICKSBURG, VA 22405 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) E 037 Continued From page 4 annual emergency preparedness training. OSM E 037 #4 stated he would get back with this surveyor. On 2/7/19 at approximately 3:00 p.m. ASM (administrative staff member) #1, the executive director, presented a list of the employees and the dates that they have completed their annual training in emergency preparedness. Of the list of 113 employees, three CNA's were not documented as having the training. CNA #12 was hired on 10/27/18. CNA #13 was hired on 10/27/18. CNA #14 was hired on 8/26/18. These three CNAs did not have documented evidence that they had completed the training on emergency preparedness. An interview was conducted on 2/7/19 at 4:12 p.m. with RN (registered nurse) #5, the nurse practice educator. When asked if she had any other documentation of the three CNAs during their orientation of the emergency preparedness plan, RN #5 stated she looked through the office and could not locate any documentation for the three CNAs. ASM #1, ASM #2, the nurse executive and ASM #3, the clinical quality specialist, were made aware of these findings on 2/7/19 at 3:36 p.m. No further information was provided prior to exit. F 000 INITIAL COMMENTS F 000 Preparation and/or execution of this Plan of An unannounced Medicare/Medicaid standard Correction does not constitute admission or survey was conducted from 2/5/19 through agreement of the provider of the truth of the facts 2/7/19. Complaints were investigated during the survey. Corrections are required for compliance alleged or conclusions set forth in the statement of with the following 42 CFR Part 483 Federal Long deficiencies. The Plan of Correction is prepared Term Care requirements. The Life Safety Code and/or executed solely because it is required by the

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y30C11

Facility ID: VA0279

provisions of federal and state law.

If continuation sheet Page 5 of 206



MAR 0 8 2019

STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			O DATE SURVEY COMPLETED
-		495246	B. WNG			02/07/2019
}	PROVIDER OR SUPPLIER		11 F			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 000 F 550 SS≠E	103 at the time of the consisted of 45 curclosed record revie Resident Rights/Ex CFR(s): 483.10(a) (\$483.10(a) Resident has a self-determination, access to persons a outside the facility, this section. §483.10(a)(1) A fact with respect and digresident in a manner promotes maintenather quality of life, reindividuality. The far promote the rights of \$483.10(a)(2) The faccess to quality caseverity of condition must establish and practices regarding	118 certified bed facility was the survey. The survey sample rent resident reviews and 10 ws. ercise of Rights 1)(2)(b)(1)(2) Int Rights. right to a dignified existence, and communication with and and services inside and including those specified in litty must treat each resident entire and in an environment that nice or enhancement of his or cognizing each resident's cility must protect and	F 000	F550 1. Resident's #74, 13, 34 36, 59, 49, 48, 55, 33, and 61 staff were contime surveyor present concern on proper digidining process. Reside 24 staff addressed lou at the time surveyor with present. Resident #40 staff were corrected a surveyor presented comproper dignified dining process are at risundignified dining process by Center Nur Executive, Nurse Pract Educator and, ADON. I included serving reside the same table and in	, 24, 8, 40 rected at ted gnified ent #8 and ud cursing was and 61 at time oncern, on g process. k for cess. n-serviced ning rse tice Education ents at	
	§483.10(b) Exercise The resident has the rights as a resident or resident of the Ur	of payment source. of Rights. e right to exercise his or her of the facility and as a citizen		room at the same time ensuring that disruptive behavior during the disexperience will be addismediately to preven disruption to residents experience.	re ning ressed t	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
Jei	495246	B. WING	STATE OF THE	1,	C 2/07/2019	
NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER (X4) ID SUMMARY STATEM	ENT OF DEFICIENCIES	1	STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 PROVIDER'S PLAN OF CORRECT		(X5)	
	ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)		COMPLETION DATE	
F 550 Continued From page 6 resident can exercise his interference, coercion, dis from the facility. §483.10(b)(2) The resident free of interference, coercing reprisal from the facility in rights and to be supported exercise of his or her right subpart. This REQUIREMENT is not by: Based on observation, starecord review, and facility was determined that the faprovide a dignified dining estables for the survey #74, #13, #34, #62, #500, #55, #33, #24, #8, #40, and 1. The facility staff failed to dining experience for Residents were observed the small cafe dining room another resident at the table meal and eating. 2. The facility staff failed to dining experience for Residents were observed to the small cafe dining room another resident at the table meal and eating. 2. The facility staff failed to dining experience for Residents, during which time both expressed a dislike of cursing. 3. The facility staff failed to funch on 2/5/19 at the same	art has the right to be ion, discrimination, and exercising his or her if by the facility in the is as required under this not met as evidenced aff interview, clinical document review, it acility staff failed to experience for fifteen of sample; Residents #36, #59, #49, #48, id #61. To provide a dignified dents #74, #13, #34, #48, #55, and #33. sitting at three tables in without food while le was served their To provide a dignified dent #8 and Resident it to address Resident it to address Resident if or approximately 29. Resident #8 and #24 if Resident #97's	F 550	4. Audit of dining process to completed 5 times a week weeks then randomly thereafter, by, Center Nu Executive, Nurse Practice Educator and ADON or designee. Variances will corrected immediately arbrought to Quality Assura and Performance Improve Committee monthly, with Committee responsible for going compliance. 5. Date of Compliance: 3/15	ek for 4 arse be and ance ement a QAPI or on-		



PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
J.			A. BUILD	ING_		"	_
		495246	B. WING		<u> </u>	Ι,	C
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	02/07/2019
WOODMO	ONT CENTER			1	I1 DAIRY LANE		
				F	FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	o o minimum r r r r r r r r r r r r r r r r r r		F	550			
i I	lunch until at least 16 minutes after her roommate was served.						
<i>3</i>	with eating on 2/5/19 a roommate received lur	nch. Resident #61 did not h eating until at least 15					
	The findings include:						
	dining experience for R #62, #500, #36, #59, #	ed sitting at three tables in om without food while					
	the small cafe dining ro There were three (3) tal closest to the door, had #48, and #59). Table 2	bles of residents. Table 1, 3 (three) residents (#62, , closest to the courtyard esidents (#74, #500, #36, est to the sink and					
	The following was obser dining observations:	rved on 2/5/19 during the					
- - - - -	Table 1: At 12:55 p.m., Resident served. The remaining 148, and #59) at this tablime. At 12:56 p.m., Residen	two residents (Residents ble were not served at this					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y3OC11

Facility ID: VA0279

If continuation sheet Page 8 of 206





AND PLAN OF CORRECTION IDENTIFICATION N		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C 02/07/2019	
	ROVIDER OR SUPPLIER	433,240		STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 550	served. The third relable was still not selected. This was 7 the same table was 17 Table 2: At 12:46 p.m., Reserved. The remaintable (Residents #8 served at this time. At 12:55 p.m., Reserved. This was 9 the same table was remaining two resident this table were new 12:56 PM, Reserved. This was 19 was served at the served. This was 19 was served at the served. This was 19 was served. This was 19 served.	esident (Resident #48) at this erved at this time. Ident #48 at table 1 was minutes after Resident #62 at a served. Sident #74 at table 2 was ning three residents at this 100, #36, and #55) were not sident #500 at table 2 was minutes after Resident #74 at a served their meal. The dents (Residents#36, and #55) ot served. Ident #36 at table 2 was 10 minutes after Resident #74 at a same table. Ident #55 at table 2 was 17 minutes after the meal for	F 5	50		
	Table 3: - At 12:49 p.m., Re were served. The (Residents #49 and served at this time. - At 12:58 p.m., Re served. This was 9 and #34 at the sam. - At 1:05 p.m., Res served. This was 9 and #34 at the sam. On 2/7/19 at 10:40 conducted with CN Assistant). CNA#1	sidents #13 and #34 at table 3 remaining two residents #33) at this table were not sident #49 at table 3 was minutes after Residents #13 re table were served. ident #33 at table 3 was for minutes after Residents #13 re table were served. a.m., during an interview A #1 (Certified Nursing stated that residents are on when their tray is brought to				

PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION			E SURVEY PLETED
		495246	B. WING				00	C
	ROVIDER OR SUPPLIER			11 DA	ET ADDRESS, CITY, STATE, ZIP CODE AIRY LANE DERICKSBURG, VA 22405	<u>_</u>	02	<u>/07/2019</u>
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		I	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUT FAG CROSS-REFERENCED TO THE APPRICATION CORRECTION SHOUT FACTOR OF THE APPRICATION CORRECTION		OULD BE		(X5) COMPLETION DATE
ĺ	the dining room from to brought to the dining of the unit for residents witheir rooms. CNA#1 to be served this way; rebe served at the same all the time. A review of the facility Standards" documents provided a positive me served table by table encouraged in the print Cn 2/7/19 at approxime Executive Director and	the kitchen; or when it is from a cart that went out to who are being served in stated residents should not sidents at a table should all time, but that this happens policy, "Dining Service ed, "Patients/Residents are eat experienceMeats areRestaurant style dining is mary dining locations" ately 2:20 p.m., the I Nurse Executive (ASM ember] #1 and #2) were lings. No further	F	550				
	chronic obstructive puli blood pressure, and de MDS (Minimum Data S assessment with an AF Reference Date) of 1/8, coded as being modera make daily life decision coded as supervision for Resident #13 was admi 10/31/18 with the diagn Alzheimer's disease, his arthritis. The most rece Set) was an admission	oses of but not limited to monary disease, high ementia. The most recent set) was a quarterly RD (Assessment /19. The resident was ately impaired in ability to s. The resident was or eating.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y3OC11

Facility ID: VA0279

If continuation sheet Page 10 of 206



	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246		A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C 02/07/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 11 DAIRY LANE FREDERICKSBURG, VA 2240		02/0//2019	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIAT			
	resident was coder impaired in ability to The resident was coassistance for eating Resident #34 was 6/29/17 with the diagranal insufficiency, and dementia. The Data Set) was a quant ARD (Assessment The resident was compaired in ability to The resident was compaired in ability to The resident was coassistance for eating Resident #62 was a 1/6/16, acute kidner The most recent MI quarterly assessment Reference Date) of coded as being sign make daily life decisored.	d as severely cognitively or make daily life decisions. Hoded as requiring limited and as requiring limited and agnoses of but not limited to stroke, high blood pressure, a most recent MDS (Minimum harterly assessment with an Reference Date) of 1/11/19. Hoded as being severely or make daily life decisions, hoded as requiring extensive and distributed to the facility on and provided to the facility on and provid	F 55	50			
	1/17/19 with diagno to: systemic inflamn and dementia. The completed. The addated 1/17/19 docur and oriented to persassessment form diabout the resident's	admitted to the facility on ses including but not limited natory response syndrome, MDS had not yet been mission nursing assessment mented the resident was alert ion, place, and time. The d not include documentation level of assistance required as of activities of daily living.					
[11/26/16 with diagno	dmitted to the facility on oses including but not limited , and encephalopathy. The					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495246	B. WING			C /07/2019	
,	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405		10112010	
(X4) ID PREF‡X TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 550	annual assessmen Reference Date) of coded as being set make daily life decicoded as requiring transfers and eating transfers and eating transfers and eating to: cerebral palsy, and the most recent M quarterly assessment Reference Date) of coded as being set make daily life decicoded as requiring Resident #49 was a 9/4/15 with diagnos pelvic fracture, frontal sca dementia MDS was an ARD (Assessment 2/12/18. The resident was an ARD (Assessment Reference Date) daily life decisions, care for all areas of including eating. Resident #48 was a 11/13/18 with diagnoses to with diagnoses to with diagnoses to with diagnoses to set was a quarterly (Assessment Referencesident was coded to the code of the	Minimum Data Set) was an t with an ARD (Assessment in 11/21/18. The resident was verely impaired in ability to sions. The resident was extensive assistance for	F 55				

PRINTED: 02/22/2019 FORM APPROVED

OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495246 B. WING 02/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 550 Continued From page 12 F 550 resident was coded as independent for eating. Resident #55 was admitted to the facility on 10/13/14, with diagnoses including but not limited to: renal mass, macular degeneration, frequent falls, and dementia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 12/19/18. The resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring limited assistance for eating. Resident #33 was admitted to the facility on 5/5/16 with diagnoses that included but are not limited to hip fracture, Alzheimer's disease, and dysphagia. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 11/10/18. The resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring extensive assistance for transfers, eating and hygiene. 2. The facility staff failed to provide a dignified dining experience for Resident #8 and Resident #24. The facility staff failed to address Resident #97's loud cursing at staff for approximately 29 minutes, during which time Resident #8 and #24 both expressed a dislike of Resident #97's cursing. Resident #8 was admitted to the facility on 1/15/18 and readmitted on 7/23/18 with diagnoses that included but were not limited to: diabetes, history of falls, anxiety, depression and dementia (1). The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 10/23/18 coded the resident as having a 14 out of 15 on the BIMS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495246	B. WING		,	2/07/2019		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405					
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 550	(brief interview for resident was cogni decisions. The resisupervision while ecoded as being on Resident #24 was a 11/13/15 and readn that included but watrial fibrillation (5) infarction (4). The ndata set), an annua ARD (assessment recoded the resident the BIMS (brief inteindicating the residemake daily decision requiring supervision was also coded as a 12/23/18 with diagnot limited to: diabethemiplegia (2) and herebral infarction (4 (minimum data set), assessment, with an date) of 1/18/19 cod 15 out of 15 on the Emental status), indiccognitively intact to resident was coded assistance with eatin On 02/05/19 at apprentice of 1/19/19 at apprentice of 1/19/19/19/19/19/19/19/19/19/19/19/19/19	mental status), indicating the tively intact to make daily dent was coded as requiring rating. The resident was also a diabetic therapeutic diet. admitted to the facility on inited 1/17/19 with diagnoses ere not limited to: diabetes, heart failure (6), and cerebral most recent MDS (minimum all day assessment, with an reference date) of 3/28/18 as having a 13 out of 15 on review for mental status), ent was cognitively intact to is. The resident was coded as in with eating. The resident requiring a diabetic dimitted to the facility on oses that included but were tes, high blood pressure, memiparesis (3) following the most recent MDS a Medicare thirty day in ARD (assessment reference ed the resident was make daily decisions. The as requiring limited	F 55					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246 NAME OF PROVIDER OR SUPPLIER			A. BUILDIN B. WING	PLE CONSTRUCTION IG	C	OMPLETED C
1 1/11	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405		02/07/2019
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 550	#97 was observed continuously at sta complaining to other about the food and On 02/05/19 at app	_	F 55	50	# To	
	Resident #97, "Car language." Resider surveyor and said, (the facility staff) ne	n you please stop using that nt #8 then turned to this "He always does this, and they sed to do something." roximately 12:32 p.m.,				
	Resident #24 was h Resident #97, "Wat However, Resident On 02/05/19 at appr minutes after the ini #97 cursing in the d was told by CNA (ce	neard and observed telling ch your language please." #97 continued cursing loudly. roximately 12:49 p.m., (29 tial observation of Resident ining room), Resident #97 ertified nursing assistant) #1, lent #97) you can't use that				
	interview was condu When asked about a Resident #24 stated	oximately 12:45 p.m., an acted with Resident #24. adjustified dining experience, "No, the language that some should not be allowed."				
i i !	nterview was condunated asked if Resider the dining room, Conown for cursing westop but sometimes was asked if the dinipother residents in the	oximately 1:47 p.m., an cted with CNA #1. CNA #1 nt #97 had a habit of cursing CNA #1 replied, "Yes, he is a have told him in the past to he does not listen." CNA #1 ng room experience for the a dining room was dignified, ursing. CNA #1 stated, "I don't				

PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

EMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	495246	B. WING		C
ME OF PROVIDER OR SUPPLIED	3		STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405	02/07/2019
REFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
interview was cor Resident #8 was dignity and respe replied, "The dinit There is a person I have told the stanothing gets done language." Review of Reside plan initiated on 1 failed to document cursing in the dinitiated on 1 failed to document of a dignified exist communication with services inside and Con 02/07/19 at application (administrative stanother information of the findin No further information of the findin No further information that is a loss of brain for the stanother information of the findin No further information of the finding No further information of	pproximately 3:53 p.m., an aducted with Resident #8. asked if she is treated with ct by the facility. Resident #8 ag room has been a problem. That curses in there constantly, aff to do something about it, but to l'm not use to that type of the residents' behavior of ag room. In the residents' behavior of ag room. In the residents' behavior of ag room. In the resident has a right ence, self-determination, and the and access to persons and doutside the facility." In the resident has a right ence, self-determination, and the and access to persons and doutside the facility." In the Executive #2, the Nurse Executive, and the self-determination was provided prior to exit. In the course with certain memory, thinking, language, avior. This information was	F 550		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y30C11

Facility ID: VA0279

If continuation sheet Page 16 of 206



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	the last and the l	(X3) DATE SURVEY COMPLETED C	
- Ann - 1	Sep. 151	495246	B. WING		02/07/2019	
NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER		11	REET ADDRESS, CITY, STATE, : DAIRY LANE EDERICKSBURG, VA 224			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE ENCY)	(X5) COMPLETION DATE
	Quadriplegia. Para function in part of y something goes were pass between your can be complete or both sides of your bone area, or it can be information was obth https://medlineplus.g. 3. Paralysis is the loo of your body. This in the website: https://medlineplus.g. 4. A stroke. When be brain stops. A stroke attack." If blood flow few seconds, the brain stops. A stroke attack." If blood flow few seconds, the brain stops. This inform website: https://medlineplus.g. 5. An arrhythmia is a rhythm of the heartbethe most common typis a disorder in the heinformation was obtawebsite: https://vsearn/query-meta?v%3Apources=medlineplus-on 3. The facility staff failunch on 2/5/19 at the	lysis is the loss of muscle our body. It happens when ong with the way messages brain and muscles. Paralysis partial. It can occur on one or ody. It can also occur in just be widespread. This ained from the website: gov/paralysis.html. So of muscle function in part of the discommation was obtained from the sis sometimes called a "brain of is cut off for longer than a pain cannot get nutrients and can die, causing fasting ation was obtained from the cov/ency/article/000726.htm. Problem with the speed or eat. Atrial fibrillation (AF) is one of arrhythmia. The cause cart's electrical system. This	F 550		Water grave	
I	lunch until at least 16 was served.	minutes after her roommate		11 F		

DEPARTMENT OF HEALTH AND HUM CENTERS FOR MEDICARE & MEDICARE					FOR	ED: 02/22/20 RM APPROVE	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DAT	O. 0938-03 E SURVEY IPLETED	
		495246	B. WING		100	С	
NAME OF	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	02	2/07/2019	
WOODM	ONT CENTER		11 DAIRY LANE FREDERICKSBURG, VA 22405				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE	
	Resident #40 was a 4/21/14. Resident a were not limited to a disorder and retenti most recent MDS (rassessment with an date) of 12/4/18, cocognitively intact. Sas requiring supervice ating. Resident #4 dated 12/11/17 failed regarding a dignified on 2/5/19 at 12:58 pobserved sitting up is resident's roommate the room and eating p.m., LPN (licensed observed entering an 2/5/19 at 1:11 p.m., to interview Resident #40 was conducted with a served Resident #40 was conducted with a served Resident #40 was conducted with a served Resident room he dining room to obe RN #2 stated Resider fining room.	admitted to the facility on #40's diagnoses included but diabetes, major depressive on of urine. Resident #40's minimum data set), a quarterly ARD (assessment reference ded the resident as being fection G coded Resident #40 sion/set up help only with 0's comprehensive care plan d to document information if dining experience. D.m., Resident #40 was n bed with no lunch tray. The was observed sitting up in lunch. On 2/5/19 at 1:08 practical nurse) #1 was not exiting the room. On his surveyor attempted to 40 regarding lunch but the alk. On 2/5/19 at 1:14 p.m., a) #1 entered the room and a meal tray. An interview RN #1 and RN #2 in the hall, #1 served Resident #40's meal and cart used to serve meal as. RN #1 stated she went to tain the resident's meal tray. In the resident's meal tray.	F 550				
	interview Resident #4 resident refused to ta RN (registered nurse served Resident #40 was conducted with I immediately after RN meal tray. RN #1 cor ray was not on the forays in resident room he dining room to ob RN #2 stated Resider dining room. On 2/6/19 at 3:02 p.m. conducted with CNA (40 regarding lunch but the alk. On 2/5/19 at 1:14 p.m., a) #1 entered the room and a meal tray. An interview RN #1 and RN #2 in the hall, #1 served Resident #40's meal and cart used to serve meal as. RN #1 stated she went to tain the resident's meal tray.					

room are supposed to be served their meal trays at the same time. CNA #2 stated, "They should be served at the same time." CNA #2 stated

PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER** COMPLETED A. BUILDING C 495246 8. WING 02/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL) PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 550 Continued From page 18 F 550 serving residents who reside in the same room at the same time has been an issue because of the way the meal trays are organized in the food carts. CNA #2 stated the meal travs are not organized in the food carts in order of the rooms. CNA #2 stated a resident's meal tray might be in one place in the food cart while the roommate's tray may be placed somewhere else in the food cart. CNA #2 was asked how she would feel if she had not been served her meal while her roommate was eating. CNA #2 stated she would be hurt and embarrassed. On 2/6/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the nurse executive) and ASM #3 (the clinical quality specialist) were made aware of the above concern. The facility policy titled, "Treatment: Considerate and Respectful" documented, "(Name of company) Centers will promote care for patients in a manner and in an environment that maintains or enhances each patient's dignity and respect in full recognition of his or her individuality." No further information was presented prior to exit. 4. The facility staff failed to assist Resident# 61 with eating on 2/5/19 at the same time her roommate received lunch. Resident #61 did not receive assistance with eating until at least 15 minutes after her roommate was served. Resident #61 was admitted to the facility on 12/18/18. Resident #61's diagnoses included but were not limited to dementia, repeated falls and high cholesterol. Resident #61's most recent MDS (minimum data set), a 14 day Medicare

PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
•	8					C	
		495246	B. WNG			ł	02/07/2019
	ROVIDER OR SUPPLIER			•	REET ADDRESS, CITY, STATE, ZIP CODE DAIRY LANE		
WOODMO	ONT CENTER				EDERICKSBURG, VA 22405	020	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(XS) COMPLETION DATE
	assessment with an A date) of 1/29/19, code as severely impaired. #61 as requiring exter with eating. Resident 12/29/18 failed to door regarding a dignified of the command	RD (assessment reference d the resident's cognition Section G coded Resident isive assistance of one staff #61's care plan dated ument information lining experience. A Resident #61 was heelchair beside her bed. It was on a table d. Resident #61's up and eating lunch. On male and a female visitor is room and were observed On 2/5/19 at 1:31 p.m., or; #8 (a speech ident #61's room, spoke to be and exited the room. On interview was conducted interview was conducted interview was conducted sing assistant) #3 in the time #61's room. CNA #3 in required assistance with the resident had eaten live feed her if her family hed serving trays." CNA time #61's room and stated her room. At this time, CNA it is room. The resident's the table over the bed. Hent's visitors if they were feed in the female in	F	550		20	
: :	stated, "No." This survivisitor if she or the male stated they were Reside surveyor asked the femmale visitor ever assists eating; the female visitor	eyor asked the female visitor was family; she ent #61's friends. This ale visitor if she or the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y3OC11

Facility ID: VA0279

If continuation sheet Page 20 of 206



MAR 0 8 2019



DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/22/2019 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING _ 495246 B. WING 02/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) F 550 Continued From page 20 F 550 few other residents who did not receive a tray then she would assist Resident #61 with eating (note- after this interview, Resident #61 was observed receiving assistance with eating). On 2/6/19 at 3:02 p.m., an interview was conducted with CNA (certified nursing assistant) #2. CNA #2 was asked if both residents in a room are supposed to be served their meal trays at the same time. CNA #2 stated, "They should be served at the same time." CNA #2 stated serving residents who reside in the same room at the same time has been an issue because of the way the meal trays are organized in the food carts. CNA #2 stated the meal trays are not organized in the food carts in order of the rooms. CNA #2 stated a resident's meal tray might be in one place in the food cart while the roommate's tray may be placed somewhere else in the food cart. CNA #2 was asked if a meal tray should be left beside a resident who requires assistance while the roommate is eating. CNA #2 stated, "No." CNA #2 was asked how she would feel if she had not been served her meal while her roommate was eating. CNA#2 stated she would be hurt and embarrassed. On 2/6/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the nurse executive) and ASM #3 (the clinical quality specialist) were made aware of the above concern. No further information was presented prior to exit. F 558 Reasonable Accommodations Needs/Preferences F 558 CFR(s): 483.10(e)(3) SS=D §483.10(e)(3) The right to reside and receive

PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) D	(X3) DATE SURVEY COMPLETED	
AME OF PROVIDER OR SUPPLIER WOODMONT CENTER SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGS) FEED COntinued From page 21 Services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and clinical record review, it was determined that the facility staff failed to provide accommodation of resident needs for one of 55 residents in the survey sample, Resident #7. The facility staff failed to ensure Resident #7: call bell (a device with a button that can be pushed to alert staff when assistance is needed), was within the resident's reach. The findings include: Resident # 7 was admitted to the facility on 101/12/17 with diagnoses that included but were not limited to lack of coordination, rheumatoid arthritis (1), Alzheimer's disease (2),			495246	B. WNG					
WOODMONT CENTER SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY CACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY	AME OF F	PROVIDER OR SUPPLIER	430240	D. 11.110		ET ADDRESS, CITY, STATE, ZIP CODE		02/07/2019	
FREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 558 Continued From page 21 services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and clinical record review, it was determined that the facility staff failed to provide accommodation of resident needs for one of 55 residents in the survey sample, Resident #7. The facility staff failed to ensure Resident #7: The facility staff failed to ensure Resident #7: The facility staff failed to ensure Resident #7: The findings include: Resident # 7 was admitted to the facility on 10/12/17 with diagnoses that included but were not limited to lack of coordination, rheumatoid arthritis (1), Alzheimer's disease (2).	WOODM	ONT CENTER	0		11 DA	AIRY LANE		_	
services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and clinical record review, it was determined that the facility staff failed to provide accommodation of resident needs for one of 55 residents in the survey sample, Resident # 7. The facility staff failed to ensure Resident # 7's call bell (a device with a button that can be pushed to alert staff when assistance is needed), was within the resident's reach. The findings include: Resident # 7 was admitted to the facility on 10/12/17 with diagnoses that included but were not limited to lack of coordination, rheumatoid arthritis (1), Alzheimer's disease (2),	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETION DATE	
hypertension (4). Resident # 7's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/20/18, coded Resident # 7 as scoring an eight on the brief interview for mental status (BIMS) of a score of 0 - 15, eight - being moderately impaired of cognition for making daily decisions. Resident # 7 was coded as requiring extensive assistance of one staff member for activities of daily living. Section G0400 "Functional Limitation in Range of Motion" coded Resident # 7 as being impaired on both sides of her upper extremities (shoulder,		services in the facility accommodation of respreferences except wendanger the health cother residents. This REQUIREMENT by: Based on observation interview and clinical determined that the faccommodation of respresidents in the survey. The facility staff failed call bell (a device with pushed to alert staff was within the resident. The findings include: Resident # 7 was adm 10/12/17 with diagnosmot limited to lack of carthritis (1), Alzheimer gastroesophageal refit hypertension (4). Resident # 7's most reset), an annual assess (assessment reference Resident # 7 as scorin interview for mental staff, eight - being mod cognition for making day was coded as requirione staff member for a Section G0400 "Function" coded Resider	with reasonable sident needs and hen to do so would or safety of the resident or is not met as evidenced in, staff interview, resident record review, it was cility staff failed to provide sident needs for one of 55 y sample, Resident #7. to ensure Resident #7's a button that can be hen assistance is needed), it's reach. itted to the facility on est that included but were cordination, rheumatoid is disease (2), it disease (3) and cent MDS (minimum data ment with an ARD edate) of 10/20/18, coded g an eight on the brief atus (BIMS) of a score of 0 erately impaired of ailly decisions. Resident # ng extensive assistance of ctivities of daily living. onal Limitation in Range of att # 7 as being impaired on	F		 Resident #7's call bell, pan paddle was corrected with surveyor present. Ali residents are at risk for bell being placed inappropriately. 100% aud was completed by manage staff to ensure that all resi have call bells in place to ritheir individual needs. Nurse Practice Educator, A or designee to in-service 1 of licensed staff on proper bell placement. Audit of ten random reside call bell placement to be completed 5 times a week weeks by ADON or designed Variances will be corrected immediately and brought Quality Assurance and Performance Improvement Committee monthly, with Committee responsible for ongoing compliance. 	dit ement idents meet ADON 00% call ents do to at QAPI r		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y3OC11

Facility ID: VA0279

If continuation sheet Page 22 of 206



PRINTED: 02/22/2019 FORM APPROVED

1418 (90.44)	(400) (% TO KN - 26) - (40, 40 pt)	FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	DN		ATE SURVEY DMPLETED
		495246	B. WING			С	
NAME OF I	PROVIDER OR SUPPLIER	e rayes organization		STREET ADDRES	S, CITY, STATE, ZIP CODE		02/07/2019
WOODM	ONT CENTER		5 1	11 DAIRY LANE	BURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PI (EAC	ROVIDER'S PLAN OF CORI CH CORRECTIVE ACTION S S-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 558	Continued From pa	age 22	F 5	58			1 3 0
	elbow, wrist, hand)	-		_			#
		,					
	On 02/05/19 at 11:	08 a.m., an observation of					is take
		lled she was lying in bed,					11
		ean, watching television. The					
	head of the bed was slightly raised and a pillow was under the upper part of Resident # 7's back. Further observation of Resident # 7 revealed she was leaning toward her left side. Observation of the call bell revealed it was a flat pressure switch.						. 2
							34
				- }			
1							
Û		Observation of the call bell's placement revealed		all a			11 11 53
1		of the mattress in the upper					- 110
		Resident # 7's head. When ocate the call bell Resident #					1.0
		slightly to the right and left and					
	struggled to remove	her right arm from under the					1 1
_1	blanket covering he	r. Resident # 7 stated, "I don't					
		Observation of Resident # 7's					
	movements reveale of motion.	d there was decreased range					
	On 02/05/19 at 3:22	p.m., an observation of					
		ed she was lying in bed,					
ľ		ean, watching television. The					
İ		s slightly raised and a pillow r part of Resident # 7's back.					
		of Resident # 7 revealed she					
		to her left side. Observation					
	of the call bell's place	ement revealed it was					
		of the mattress in the upper					10
		Resident # 7's head. When					
	asked if she could id 7 stated, "I don't kno	ocate the call bell Resident # ow where it is."					
	On 02/06/19 at 8:01	a.m., an observation of					
	Resident # 7 was lyi	ng in bed, watching		1			
		d of the bed was slightly					
		vas under the upper part of					1
1	Resident # 7's back.	Further observation of		[

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		ATE SURVEY OMPLETED
		495246	B. WING_			2/07/2019
	PROVIDER OR SUPPLIER	14 DAIPY LANG			20112013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	Resident # 7 revealed her left side. Observat placement revealed it Resident # 7's right si When asked if she concession. The head raised and a pillow was resident # 7 revealed her left side. Observat placement revealed it Resident # 7 revealed her left side. Observat placement revealed it Resident # 7's right side. When asked if she concession for falls related to of safety awareness are initiated 10/25/2017, with 12/12/2018 documenterisk for falls related to of safety awareness are initiated 10/25/2017. Funder "Interventions", light within reach while to the bed. Date initiated 10/20/7/19 at 8:15 aux Resident # 7's call bell was resident # 7 could reach saked if the call bell was resident # 7 could reach saked if the reach motion." When asked if or the placement of a contract of the placement of	d she was leaning slightly to tion of the call bell's was lying on the bed, on de just below her shoulder. uld locate the call bell I don't know where it is." I.m., an observation of g in bed, watching of the bed was slightly as under the upper part of further observation of she was leaning slightly to ion of the call bell's was lying on the bed, on de just below her shoulder. uld locate the call bell No." are plan for Resident # 7 a revision date of ed, "Focus. Resident is at cognitive impairment, lack and impaired mobility. Date Revision date: 12/12/2018." it documented Place call in bed or close proximity ed: 10/25/2017."	F 55	58		

PRINTED: 02/22/2019 FORM APPROVED

CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES	Waynessa Ti		OMB N	NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G		TE SURVEY MPLETED
			5 14010		С	
NAME OF I	PROVIDER OR SUPPLIER	495246	B. WING	THE STATE OF THE S		2/07/2019
NAME OF	PROVIDER OR SUPPLIER	- Marine Compression and Compression Compr		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
WOODM	ONT CENTER			11 DAIRY LANE		
	OLD BAND	W DIATEMENT OF DEPOSITOR		FREDERICKSBURG, VA 22405		11 1000
PREFIX TAG			PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 558	Continued From p	nage 24	F 55	30		
	can reach it." Wh	en asked why it was important	1 33			
		ave access to their call bell, n case they have an accident, if				
	they are in pain to	get a hold of the staff for their needs met." When	:			
		he placement of the call beli				N TREAT
		d, CNA # 2 stated, (At least ring rounds and when you go		IIIV 85		Alou III
	into the room."	ring rounds and when you go				
		30 a.m., an observation of				
		bell placement was conducted d nurse) # 8, unit manager.				2/12
	When asked if the	call belt was placed in a				100
	•	ent # 7 could reach and ated, "No" and immediately				8 1
		all bell within reach of Resident				
		When asked to describe the placement of a cell bell for a				
		ated, "Should be in reach				
	within the resident's	s ability." When asked why it				
		resident to have access to 8 8 8 8 8 8 8 9 9 9 9 9 9 9 9 9 9 9 9				
	able to get a hold of	of staff for assistance and				
		how often the placement of be checked, RN # 8 stated,				
	"Every time we (sta	off) go into the resident's				
	room."				100	- 76
		roximately 3:45 p.m., ASM				
	(administrative staff	f member) #1, the executive #2, executive nurse, were			-	
	made aware of the					× 1
	No further informati	on was provided prior to exit.		= =		
	References:					
		ase. It leads to inflammation		a	, u	

PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
495246 B. WING		С	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP	CODE	02/07/2019	
WOODMONT CENTER 11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACTUAL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACTUAL TAG CROSS-REFERENCED TO DEFICIENCIES)	TION SHOULD B	SE COMPLETION	
F 558 Continued From page 25 affect other organs. This information was obtained from the website: https://www.nim.nih.gov/medlineplus/swallowingdi sorders.html. (2) A swallowing disorder. This information was obtained from the website: https://www.nim.nih.gov/medlineplus/swallowingdi sorders.html. (3) Fear. This information was obtained from the website: https://www.nim.nih.gov/medlineplus/anxiety.html #summary. (4) High blood pressure. This information was obtained from the website: https://www.nim.nih.gov/medlineplus/highbloodpr essure.html. F 578 Request/Refuse/Dscntnue Trmnt;FormIte Adv Dir CFR(s): 483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written Information to all adult residents concerning the right to accept or refuse	ediately upong it to staff 6/2019, by the facility a o have MD order in status. 10 ent resident by Center N	on f's are at n 00 % ts	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y3OC11

Facility ID: VA0279

If continuation sheet Page 26 of 206



NAME OF PROVIDER OR SUPPLIER STREET ADD	DRESS, CITY, STATE, ZIP CODE	C 02/07/2019
NAME OF PROVIDER OR SUPPLIER STREET ADD		
WOODMONT CENTER 11 DAIRY L/F FREDERIC	CKSBURG, VA 22405	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG C	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced	designee to ensure that Code Status was correctly identified on Physician's orders. Nurse Practice Educator, ADON or designee to in-service 100% of licensed nursing staff on proper procedure in regards to MD order for code status. Social Service Director and/or Director of Nursing will audit all new admissions for appropriate documentation of Code Status 5 X week for four weeks then weekly thereafter. Social Services to address code status in Quarterly Care Plan Meetings and ensure appropriate orders in place. Date of Compliance: 3/15/19	

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 02/22/2019 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING_ 495246 B. WING 02/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE **WOODMONT CENTER** FREDERICKSBURG, VA 22405 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 578 Continued From page 27 F 578 Resident #26 was admitted to the facility on 10/30/18. Resident #26's diagnoses included but were not limited to fractured vertebra, acute kidney failure and urinary tract infection. Resident #26's most recent MDS (minimum data set), a 30 day Medicare assessment with an ARD (assessment reference date) of 11/25/18, coded the resident's cognition as severely impaired. Review of Resident #26's clinical record revealed a Virginia Department of Health Durable Do Not Resuscitate Order form dated 2/5/18. Resident #26's comprehensive care plan dated 10/31/18

this no."

documented, "Resident has established advanced directive and/or DNR (do not resuscitate) order in place...DO NOT

the physician on 2/5/19 failed to reveal documentation of the resident's code status.

On 2/6/19 at 4:05 p.m., an interview was

the admissions records or the advance directives." When asked if a resident should have a physician's order for his or her code status, LPN #3 stated, "Well yeah." Resident #26's current active physician's order form signed by the physician on 2/5/19 was reviewed with LPN #3. LPN #3 stated the form should reflect the resident's current active physician's orders. When asked to confirm that the form did not contain a current active order reflecting Resident #26's code status, LPN #3 stated, "According to

conducted with LPN (licensed practical nurse) #3. LPN #3 was asked where nurses reference a resident's code status. LPN #3 stated.

"Sometimes in the computer or in the chart under

RESUSCITATE (DNR)..." Review of Resident #26's current active physician's order form (a listing of all active physician's orders), signed by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246 NAME OF PROVIDER OR SUPPLIER		C-020 (-10, 19-7		(X3) DATE SURVEY COMPLETED C 02/07/2019
OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 11 DAIRY LANE FREDERICKSBURG, VA 22405	CODE
D SUMMARY STATEMENT OF DEFICIENCIES IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
On 2/6/19 at 5:39 prember) #1 (the expurse executive) are specialist) were mast concern. No further information of the folial consult with the resionsistent with his consults in injury and expresentative(s) when a significant characterioration in healt at in either life-the inical complications (a) A need to alter the need to discontinue eatment due to adverse a new for a decision to transident from the facility of this section, when making notinus (a) (i) of this section,	a.m., ASM (administrative staff recutive director), ASM #2 (the red ASM #3 (the clinical quality de aware of the above on was presented prior to exit. Injury/Decline/Room, etc.) (4)(i)-(iv)(15) fication of Changes. Inediately inform the resident; dent's physician; and notify, or her authority, the resident there istens the potential for requiring in; ange in the resident's physical, cial status (that is, a h, mental, or psychosocial ireatening conditions or so; eatment significantly (that is, a e an existing form of the erse consequences, or to m of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that		F580 1. Resident #71 Phof Advair not be administered for November 2018 2019. Resident # notified physicial late administration on 8 10/3/18. 2. All residents are Physician not be medication not administered an administered an administration. current resident Administration Flast 30 days were Center Nurse Exception.	nysician notified eing r dates during and January #35 ADON an on 2/6/19 of ion of /30/18 and at risk for eing notified of being d late 100% audit of s Medication Records for the e audited by ecutive, ADON
	CORRECTION OVIDER OR SUPPLIER SUMMARY (EACH DEFICIE REGULATORY C Continued From pa On 2/6/19 at 5:39 p member) #1 (the ex- nurse executive) and specialist) were ma- concern. No further information Notify of Changes (I CFR(s): 483.10(g)(14) Notify A facility must immonsult with the resi- consistent with his or exercise in injury and I A) An accident invo esults i	OVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 28 On 2/6/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the nurse executive) and ASM #3 (the clinical quality specialist) were made aware of the above concern. No further information was presented prior to exit. Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) 483.10(g)(14) Notification of Changes. A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident expresentative(s) when there is- A) An accident involving the resident which expresentative(s) when there is- A) An accident involving the resident which expresentative(s) when there is- A) An accident involving the resident which expresentative in injury and has the potential for requiring hysician intervention; B) A significant change in the resident's physical, electrioration in health, mental, or psychosocial atus in either life-threatening conditions or inical complications); C) A need to alter treatment significantly (that is, need to discontinue an existing form of exatment due to adverse consequences, or to ommence a new form of treatment); or C) A decision to transfer or discharge the sident from the facility as specified in	OVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 28 F 57: A SM #2 (the clinical quality state) F 58: Continued From page 28 F 57: A SM #2 (the clinical quality state) F 58: Continued From page 28 F 57: A SM #2 (the clinical quality state) F 58: A Sulfit From page 28 F 57: A SM #2 (the clinical quality state) F 58: F 58: Continued From page 28 F 57: A SM #2 (the clinical guality state) F 58: A Sulfit From page 28 F 57: A SM #2 (the clinical guality state) F 58: A Sulfit From page 28 F 57: A SM #2 (the clinical guality state) F 58: A Sulfit From page 28 F 57: A SM #2 (the clinical guality state) F 58: A Sulfit From page 28 F 57: A SM #2 (the clinical guality state) F 58: A Sulfit From page 28 F 57: A Sulfit From page 28 F 57	OVIDER OR SUPPLIER ## A BUILDING B WING STREET ADDRESS, CITY, STATE, ZIP ## TO CENTER SUMMARY STATEMENT OF DESICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 28 Con 2/6/19 at 5:39 p.m., ASM (administrative staff member) #1 (the executive director), ASM #2 (the nurse executive) and ASM #3 (the clinical quality specialist) were made aware of the above concern. **No further information was presented prior to exit. doity of Changes (Injury/Decline/Room, etc.) **SFR(s): 483.10(g)(14) (h)-(iv)(15) ## A83.10(g)(14) Notification of Changes. A Bull DING PREFIX TAGE **TAGE **TAGE **PREFIX TAGE **CROSS-REFERENCED TO CORSS-REFERENCED TO CORSS-REFER

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT	E SURVEY PLETED
		495246 B. WNG				C
	PROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CODE DAIRY LANE EDERICKSBURG, VA 22405		<u>/07/2019</u>
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	when there is- (A) A change in roo as specified in §483 (B) A change in res State law or regulat (e)(10) of this sectio (iv) The facility mus update the address phone number of th representative(s). §483.10(g)(15) Admission to a com that is a composite §483.5) must disclo its physical configur locations that compi part, and must spec room changes betw under §483.15(c)(9) This REQUIREMEN by: Based on resident if facility document rev review, it was deterr failed to notify and or regarding a possible two of 55 residents i Resident #71, and # 1. The facility staff fi physician when the i was not administere November 2018 and 2. The facility staff fi physician was notifieneed to administer p	am or roommate assignment 3.10(e)(6); or ident rights under Federal or tions as specified in paragraph on. It record and periodically (mailing and email) and ite resident sposite distinct part. A facility distinct part (as defined in se in its admission agreement ation, including the various rise the composite distinct ify the policies that apply to een its different locations. It is not met as evidenced interview, view and clinical record mined that the facility staff consult with the physician enced to alter treatment for in the survey sample, 35. ailed to notify Resident #71's resident's medication Advair d on multiple dates in January 2019.	F 580	 Nurse Practice Educe ADON or designee to 100% of licensed nu on proper physician when medications a administered or administered or administered or administered or administered or administered by A designee 5 X week for and randomly theres review for omitted in or medications delivensure that Physician notified appropriate Variances will be confirmediately and brown Quality Assurance ar Performance Improve Committee monthly, Committee responsion ongoing compliances Date of Compliances 	o in-service rsing staff notification re not ninistered MARS/Tars DON or or 4 weeks, after, to nedications ered late to n was ly. rected ought to nd rement , with QAPI ble for	

PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

	(EACH DEFICIENCE REGULATORY OR RESIDENCE RESIDEN	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495246	B. WING _			C)2/07/2019	
F				STREET ADDRESS, CITY, STATE, ZIP COE 11 DAIRY LANE FREDERICKSBURG, VA 22405		2/0//2019	
PRE	FIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETION DATE	
F	the facility late, over time for the 8:00 p.r medications on 8/30. The findings include 1. Resident #71 wa 10/1/18. Resident # were not limited to disease (2), low back Resident #71's most set), a quarterly asset), a quarterly asset (assessment references resident as being control of the set of	r an hour past the scheduled in., administration of two 0/18 and 10/3/18. It is admitted to the facility on 1/15 diagnoses included but hronic obstructive pulmonary in the pain and anxiety disorder. It recent MDS (minimum data pessment with an ARD lace date) of 1/8/19, coded the ignitively intact. If 71's clinical record revealed lated 10/17/18, for, Advair is)/50 mcg and to inhale one	F 58	10			
	January 2019 MARs records) failed to revito the resident (as evito with no documented following dates and ti-11/1/18 at 9:00 p.m. 11/3/18 at 9:00 p.m. 11/30/18 at 9:00 p.m. 1/9/19 at 9:00 p.m. Nurses' notes for thos medication was admi	se dates failed to reveal the nistered. ident #71's January 2019 was not administered to the ing dates and times:	0				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y3OC11

Facility (D: VA0279

If continuation sheet Page 31 of 206



ICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	COM	(X3) DATE SURVEY COMPLETED C				
11-22	495246	B. WNG		02	2/07/2019			
NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405					
(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	LD 8E	(X5) COMPLETION DATE			
9/19 at 9:00 a.m. 29/19 at 9:00 a.m these dates abov als and documen	and . e, the nurses circled their ted the medication was not	F 580						
/18 documented for respiratory co ima, COPDMed itor for effectiven s/symptoms of si	"Resident exhibits or is at mplications related to dicate as ordered and ess and observe for de effects. Report to							
lucted with Resided he was not get losed to "for a wh	ent #71. The resident ting his Advair as he was ile" but that had							
lucted with LPN (#3 was asked he cations and treat #3 stated, "They lication administr n asked what is r es on the MAR o ign off, LPN #3 s hey didn't do it." nt if nurses sign a . LPN #3 stated, ed, either they hel upposed to expla #3 was asked if A y STAT (immedia	licensed practical nurse) #3. by nurses evidence the ments they administer. sign off on the MAR ation record) and TAR." neant if there are blank, r TAR and the nurses did tated, "In reality it means LPN #3 was asked what is and circle their initials on the "Usually if signed and d it, or couldn't give it, they ain on the back of the MAR." Advair is contained in the on the lower than the low (a box containing)							
	SUMMARY S' (EACH DEFICIENCE REGULATORY OR tinued From page 9/19 at 9:00 a.m. 19/19 at 9:00 a.m. 19/18 documented 1/5/18 documented 1/5/19 at 12:20 p. 1/5/19 at 12:2	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) tinued From page 31 9/19 at 9:00 a.m. and 19/19 at 9:00 a.m. hese dates above, the nurses circled their als and documented the medication was not lable on the back of the MAR. dent #71's comprehensive care plan dated //18 documented, "Resident exhibits or is at for respiratory complications related to ma, COPDMedicate as ordered and itor for effectiveness and observe for s/symptoms of side effects. Report to ician as indicated." //5/19 at 12:20 p.m., an interview was fucted with Resident #71. The resident d he was not getting his Advair as he was osed to "for a while" but that had rightened itself out." //6/19 at 4:05 p.m., an interview was fucted with LPN (licensed practical nurse) #3. #3 was asked how nurses evidence the cations and treatments they administer. #3 stated, "They sign off on the MAR iciation administration record) and TAR." In asked what is meant if there are blank, ses on the MAR or TAR and the nurses did right off, LPN #3 stated, "In reality it means they didn't do it." LPN #3 was asked what is tif nurses sign and circle their initials on the LPN #3 stated, "Usually if signed and d, either they held it, or couldn't give it, they upposed to explain on the back of the MAR." #3 was asked if Advair is contained in the y STAT (immediate) box (a box containing uses medications that can be accessed for any server if needed). LPN #3 stated Advair is ined in the facility omnicell (a machine	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Itinued From page 31 9/19 at 9:00 a.m. and 19/19 at 9:00 a.m. and 10/18 documented the medication was not lable on the back of the MAR. Ident #71's comprehensive care plan dated 1/18 documented, "Resident exhibits or is at for respiratory complications related to ma, COPDMedicate as ordered and ditor for effectiveness and observe for 19/19/19/19/19/19/19/19/19/19/19/19/19/1	SUMMARY STATEMENT OF DERICENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Itinued From page 31 J/19 at 9:00 a.m. and 19/19 at 9:00 a.m. hese dates above, the nurses circled their is and documented the medication was not lable on the back of the MAR. dent #71's comprehensive care plan dated //18 documented, "Resident exhibits or is at for respiratory complications related to ma, COPDMedicate as ordered and itior for effectiveness and observe for //symptoms of side effects. Report to ician as indicated." //5/19 at 12:20 p.m., an interview was ucted with Resident #71. The resident d he was not getting his Advair as he was osed to "for a while" but that had ghtened itself out." //6/19 at 4:05 p.m., an interview was ucted with LPN (licensed practical nurse) #3. #3 was asked how nurses evidence the cations and treatments they administer. #3 stated, "They sign off on the MAR ication administration record) and TAR." n asked what is meant if there are blank, so on the MAR or TAR and the nurses did gn off, LPN #3 stated, "In reality it means hey didn't do it." LPN #3 was asked what is it if nurses sign and circle their initials on the LPN #3 stated, "They relity it means hey didn't do it." LPN #3 was asked what is it if nurses sign and circle their initials on the LPN #3 stated, "Usually if signed and d, either they held it, or couldn't give it, they upposed to explain on the back of the MAR." Was assked if Advair is contained in the y STAT (immediate) box (a box containing us medications that can be accessed for any ent if needed). LPN #3 stated Advair is	SUMMARY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Itinued From page 31 9/19 at 9:00 a.m. and 9/19 at 9:00 a.m. hese dates above, the nurses circled their is and documented the medication was not lable on the back of the MAR. dent #71's comprehensive care plan dated /18 documented, "Resident exhibits or is at for respiratory complications related to ma, COPDMedicate as ordered and litor for effectiveness and observe for sisymptoms of side effects. Report to ician as indicated." #/5/19 at 12:20 p.m., an interview was ucted with Resident #71. The resident do he was not getting his Advair as he was osed to "for a while" but that had githened itself out. #/6/19 at 4:05 p.m., an interview was ucted with LPN (licensed practical nurse) #3. #3 was asked how nurses evidence the cations and treatments they administer. #5/19 at 10:05 p.m., an interview was ucted with LPN (licensed practical nurse) #3. #3 was asked how nurses evidence the cations and treatments they administer. #5/19 at 4:05 p.m., an interview was ucted with LPN (licensed practical nurse) #3. #3 was asked how nurses evidence the cations and treatments they administer. #5/19 at 4:05 p.m., as interview was ucted with LPN (licensed practical nurse) #3. #3 was asked how nurses evidence the cations and treatments they administer. #5/19 at 4:05 p.m., as interview was ucted with LPN (licensed practical nurse) #3. #3 was asked how nurses evidence the cations and treatments they administer. #5/19 at 4:05 p.m., as interview was ucted with LPN (licensed practical nurse) #3. #3 was asked how nurses evidence the cations and treatments they administer. #5/19 at 4:05 p.m., an interview was ucted with left had been considered the late of the l			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 495246		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C			
100 D W.W.	PROVIDER OR SUPPLIER	433240	STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405			_] 02	02/07/2019	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(-1011-00111-0111-011-011-011-01-00-00			BE	(X5) COMPLETION DATE	
	provided by that ph various medications each resident). LPI facility process for administration, if no #3 stated, "They cathe right dose, the cond, let the physicial patient know, call the (the medication) from pharmacy) and let that you didn't give in physician should be "Cause it's a med (not they need to know if Complications could aware." On 2/6/19 at 5:39 put member) #1 (the executive) and specialist) were made concern. The facility policy title Administration: Generouse, Med Tech, or	armacy, containing many is that can be accessed for N #3 was asked about the ensuring Advair is available for it in the medication cart. LPN in check the omnicell. If it's omnicell will let you pull it. If in know it's not here, let the epharmacy and ask to send in backup (a backup ne rp (responsible party) know it." When asked why the notified, LPN #3 stated, nedication) they ordered and if they got it or not. I happen so they need to be in., ASM (administrative staff ecutive director), ASM #2 (the diash #3 (the clinical quality is aware of the above and, "Medication eral" documented, "A licensed medication aide, per state	F 58	30				
	patientsIf discrepar not available, notify p	inister medications to ncies, including medication physician/advanced practice or pharmacy as indicated"						
9	(1) Advair is used to a wheezing, shortness chest tightness cause nformation was obtai	treat difficulty breathing, of breath, coughing, and ed by asthma. This ined from the website: by/druginfo/meds/a699063.h				4		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		NSTRUCTION	, ,	C C	
		495246	B. WING	24	02	/07/2019	
	NT CENTER		STRE 11 D FRE	DE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 580	disease) makes it htwo main types are emphysema. The relong-term exposure damage the lungs. smoke. Air pollutio can also cause it." from the website: https://vsearch.nlmmeta?v%3Aproject medlineplus-bundle 76.178186840.1550688 2. The facility staff physician was notifineed to administer Resident #35 late, the facility late, ove time for the 8:00 p. medications on 8/3 Resident #35 was 5/22/18 with the diahip fracture, atrial fells, inguinal hernimost recent MDS (quarterly assessment Reference Date) ocoded as being condaily life decisions being independent	cobstructive pulmonary and for you to breathe. The chronic bronchitis and main cause of COPD is to substances that irritate and This is usually cigarette in, chemical fumes, or dust This information was obtained on the information was obtained to end information of two on the information of two on the information of two on the information was obtained to the facility on agnoses of but not limited to information, high blood pressure, a, and cardiomyopathy. The information was a cent with an ARD (Assessment of 11/23/18. The resident was gnitively intact in ability to make the resident was coded as for transfers, locomotion, and toileting and as requiring	F 580				
		nical record revealed a lated 8/22/18 that documented					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		495246	B. WING			02/07/2019	
NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER				0210112013			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG				
F 580	for 4 hours daily.	age 34 go on LOA [leave of absence] rse's notes revealed the	F 5	80			
	"Resident signed that he was going going to church to contacted at 10pn not back at facility contacted. Residesoon after and was	ed 8/30/18 documented, but at 1:30pm, today and stated to (name of bank) and not night. Cousin and friend were not today because resident was. Unit manager on call was ent made contact with facility is reported to unit manager on the will pick up resident from ocation)"					
	entry: This RN waresidents (Sic.) fat following his department on the resident was local contact with RP to resident was local contact was made and friend, neither whereabouts. DO Nursing staff was office non emerge residents (Sic.) fat 10:30pm, this RN (resident) had cal was at the Firestodue to not having This writer went to Resident was four (location) sitting of the left his bank care	red 8/31/18 documented, "Late as contacted by nursing staff of flure to return to the facility rture for the bank earlier in the g staff was advised to make see if they knew where seed. This RN was advised that with residents (Sic.) cousing of which knew of his lown was notified of incident. advised to call the sheriffs (Sic.) ency number to report the flure to return. At approximately was notified by staff that led the facility and stated he ne and was unable to get back enough money for the cab ride. To pick up resident shortly after. In the ground. Resident stated and (Sic.) back at the facility and a ride back. Resident returned					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246		(X2) MULTIPLE CONSTRUCTION A, BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 02/07/2019			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 580	resident of returning need to be able to to Resident expressed was asked where he leaves the facility signed to the (name of usually in the shopphospital. Resident approximately 11:3. A nurse's note date "Patient left facility supposed to return facility at 7:50 p.m., Station in (location) returned at 9:30PM the Bus Station gaveducation given on out alone he must lively ways and he must lively and he ways and he must lively supposed to return facility at 7:50 p.m., Station in (location) returned at 9:30PM the Bus Station gaveducation given on out alone he must lively ways and he must lively supposed to recipied for calcium surely supposed to return facility at 7:50 p.m. A review of the clin dated 5/23/18 for Codaily for calcium surely supposed to recipied for calcium surely supposed for calcium surely	stressed the importance to the g in a timely manner and the ake his evening medicine. It understanding. Resident e usually goes when he of another incident occurs we are Resident stated that he of bank) on (location) and is bing center above or below the returned to facility at Opm." In the stated that he of bank of the preturned to facility at Opm." In the stated that he of bank of the preturned to facility at Opm." In the stated that he of bank of the preturned to facility at Opm." In the stated that he of the preturn that the stated that the stated that the stated that the stated that the eive the above medications at the preturn that the stated that the eive the above medications were ministered at 8:00 p.m., when occumented in nurses' notes, as building between 1:30 p.m., ere was no evidence that the fied, consulted for orders to	F	580				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246		Mary State and State of the	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE 1 DAIRY LANE REDERICKSBURG, VA 22405	1 02	/07/2019
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SH		(X5) COMPLETION DATE
F 580	that the resident we medications above these medications administered at 8:0 documented in nur building between 2 was no evidence the consulted for order medications late. On 2/7/19 at 1:24 pt., was asked above the a resident is miss medications, should be called to be given or not. On 2/7/19 at 2:20 pt. Executive Director member] #1) and by When asked about outings into the coreturning to the fact he was alert and of Interview for Mental (cognitively intact), aware of the resideright to go out if he about the resident' was late returning that the doctor should at the fact of the content of the resident' was late returning that the doctor should be selected in the selected in	tober 2018 MAR documented as to receive the same two at 8:00 p.m. On 10/3/18, were documented as 20 p.m., when the resident was ses' notes as not being in the 2:10 p.m. and 9:30 p.m. There that the physician was notified, as to administer the 2.50 p.m., in an interview with LPN but the process staff follows out on leave long enough to LPN #4 stated the physician overify if the medications can a co.m., in an interview with the (ASM [administrative staff burse Executive, ASM #2. It the resident's unsupervised mmunity and issues he had of sility timely, ASM #1 stated that riented, his BIMS (Brief al Status exam) was a 15 She stated the physician was ent's outings and that it was his a wanted to. When asked as missed medications when he to the facility, ASM #1 stated and whether or not to administer	F 580			
30	Absence/Therapeu	ility policy, "Leave of utic Leave" did not include tures if the resident was out				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
		495246	B. WING			02/07/2019	
WOODMONT O	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405			033072010	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO ' DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
A reference of the control of the co	eview of the fact sident Dischard ange of Status' ysician/prescribident to take a discian/prescribidications the relief on leave!! sence for less thange in the time edication, if append that dose of e policy did not build be if the relief the resident metaturn. Cal-Gest Antaletary supplementation to the same also is artburn, acid in available with commatted the commatter of the ps://medlineplute	time and missed medications. cility policy, "Leave of Absence, ge with Medication or Other of documented, "When a Facility per provides an order for the leave of absence, the per should specify the period of the sident is to take with them of the resident is taking a leave of the period of a repriate, to avoid the need to medication with the resident" address what the procedure period of the medications due to a stion was provided. cid - "Calcium carbonate is a medication with the amount of the diet is not enough. Calcium body for healthy bones, system, and heart. Calcium used as an antacid to relieve digestion, and upset stomach. It without a prescription."	F 580				

PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 580 Continued From page 38 Metoprolol is in a class of medications called beta blockers. It works by relaxing blood vessels and slowing heart rate to improve blood flow and decrease blood pressure." Information obtained from https://medlineplus.gov/druginfo/meds/a682864.h tml F 583 SS=D CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(i) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service		IDENTIFICATION NUMBER: A. BUILDIN		DING		(X3) DATE SURVEY COMPLETED C	
		433240	STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405			2/07/2019	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE	
F 583	Metoprolol is in a cla blockers. It works by slowing heart rate to decrease blood pres Information obtained https://medlineplus.g tml Personal Privacy/Co	ass of medications called beta relaxing blood vessels and improve blood flow and sure." I from jov/druginfo/meds/a682864.h	F 580	F583			
	The resident has a riconfidentiality of his records. §483.10(h)(l) Person accommodations, metelephone communicand meetings of famithis does not require private room for each §483.10(h)(2) The faresidents right to perright to privacy in his written, and electronithe right to send and mail and other letters materials delivered to including those delivered to incl	al privacy includes edical treatment, written and ations, personal care, visits, ily and resident groups, but the facility to provide a resident. cility must respect the sonal privacy, including the or her oral (that is, spoken), c communications, including promptly receive unopened packages and other other facility for the resident, pered through a means other		1. Resident #50 mail of before arriving to he Resident # 50 is cut opening packages staff due to risk of receiving in the madeen added to his of have packages open presence of staff for a literal risk. Social Service Activities Director of the social Service Activities Director of	nim. rrently in front of what he is il, this has care plan to ned in the or his safety. ing mail are ces/		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID Y3OC11

Facility ID: VA0279

If continuation sheet Page 39 of 206



	CO TOTAL COLOR II CE C	A THE TOTAL OF THE TOTAL OF				0,0000 000	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			(X3) DATE SURVEY COMPLETED	
			B. WNG			С	
		495246			02	/07/2019	
	PROVIDER OR SUPPLIER		11 [REET ADDRESS, CITY, STATE, ZIP CODE DAIRY LANE EDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 583	(ii) The facility must Office of the State Lito examine a resider administrative record law. This REQUIREMEN by: Based on resident in facility policy review was determined the resident mail was resident facility staff faile received unopened in The findings include: Resident #50 was as 8/20/17. Diagnosis in to: high blood pressure obstructive pulmonal sleep apnea (2). The most recent MD annual assessment, reference date of 7/2 having a score of 15 interview for mental swas cognitively intaction. On 02/05/19 at approinterview was conducted the course of the most part. A coursupposed to get a part.	allow representatives of the ong-Term Care Ombudsman nt's medical, social, and ds in accordance with State T is not met as evidenced Interview, staff interview, and clinical record review, it facility staff failed to ensure ceived unopened for one of urvey sample, Resident #50. If to ensure Resident #50 mail. Idmitted to the facility on included but were not limited ure, depression, chronic ry disease (1) and obstructive S (minimum data set), an	F 583	100% of current resi are alert and oriente that they are receiving mail unopened by 3/3. 3. Business office and F Staff were inserviced Delivering mail and p patients unopened of 4. Activities to audit 10 residents receiving n to ensure mail is uno when delivered. Var be corrected immedi brought to Quality A and Performance Im Committee monthly, Committee responsil ongoing compliance. 5. Date of compliance:	d to ensure ng their (8/19. Recreation of on one one 1/10/19. I random nail weekly opened riances will liately and ssurance oprovement with QAPI ble for		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246		A. BUILDING	PLE CONSTRUCTION G	СО	(X3) DATE SURVEY COMPLETED C	
	ROVIDER OR SUPPLIER	495246	B. WING	STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405		02/07/2019	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
F 583	about it (Sic). I han Amazon. They (the it was a weapon. I was going to use a complained about me before they op. The social worker p.m., documented rotator cuff pain as his flexibility and p. #50) continues to that might not be a gym equipment, k that anything he was reviewed first so the inappropriate to the complete of the comple	d ordered some batons from e facility administration) thought have a 'bum' shoulder, and I them to stretch my arms. After I this, they said they would ask bened my packages." note dated 8/21/18 at 3:07 "(name of Resident #50) has a and goals will focus on improving beain level. (Name of Resident order equipment from Amazon appropriate for our facility (i.e. arate gear, etc.). He is aware wants to order should be that he does not bring anything	F 58	83			
		ducted with ASM (administrative the Executive Director. ASM #1					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495246	B. WING		02/07/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 583	getting opened mail. of Resident #50), toke that a while back bef received an opened history of getting were previous administrate However when I four the staff on not opened told him that he can't And now staff are no unless he consents a presence." On 02/07/19 at appre facility provided this titled "Recreation Sta which documented, delivered unopened. by OSM #12, activitic activities, and OSM: The comprehensive 2019 failed to mention should be delivered. On 02/07/19 at appre the Executive Direct Executive, and ASM Specialist, were made The facility policy titl with a most recent re documented, "Person accommodations, me telephone and election telephone and election The staff on not opened to the staff on not open told him that he can't And now staff are no unless he consents a presence." On 02/07/19 at appre the Executive Direct Executive, and ASM Specialist, were made The facility policy titl with a most recent re documented, "Person accommodations, me telephone and elections."	dents had complained of ASM #1 replied, "Yes (name dome while I made a tour, ore I got here, he had package. The resident had a apons in the mail, so the property of the package and out about this I educated fing a residents mail. We also at have any weapons here, at to open any of his package and they open it in his approximately 11:00 a.m., the surveyor with a document aff Education" dated 1/8/19, "Resident mail will be." The document was signed as assistant, OSM #13, #2, activities assistant. Care plan dated February on how Resident #50's mail approximately 5:45 p.m., ASM #1, or and ASM #2, the Nurse #3, Clinical Quality the aware of the findings. Led "Privacy Rights: Patient" evision date of 11/28/16,	F 58	33		

PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495246	8. WING	ELIX.	0:	C 2/07/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
ñ	1. Disease that make can lead to shortness types are chronic brown the main cause of the control of the main cause of the substances that in this is usually cigare chemical fumes, or conformation was obtained by the chemical fumes, or conformation was obtained by the conformation was obtained by the cours because of note that the course that	es it difficult to breath that is of breath). The two main prochitis and emphysema. COPD is long-term exposure ritate and damage the lungs. Sette smoke. Air pollution, dust can also cause it. This pained from the website: gov/medlineplus/copd.html. apnea (OSA) is a problem in a pauses during sleep. This pairowed or blocked airways. Sobtained from the website: pov/ency/article/000811.htm. Abuse/Neglect Policies (Policies and procedures that: it and prevent abuse, tion of residents and esident property, sish policies and procedures challegations, and the training as required at the is not met as evidenced siew, facility document review wiew, it was determined that to implement the facility of 55 residents in the	F 607	1. Resident #3, 261 and facility failed to implifacility abuse policy. 2. All residents in the firisk. 3. NPE and or designed 100% of staff on Abuse with attention to rechour time frame. 4. Further abuse allegate be reviewed by the Administrator, CNE commediately. Varian corrected immediate reviewed at QAPI mediate.	ement acility are at in-serviced use Policy quired 2 ations will or designee ces will be ely and onthly.	
	survey sample, resid	lents #3, #261 and #262.		5. Date of Compliance:	: 3/15/19 	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y3OC11

Facility ID: VA0279

If continuation sheet Page 43 of 206





		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			(X3) DATE SURVEY COMPLETED C	
		495246	B. WING		02/07/2019		
	ROVIDER OR SUPPLIER		11 D	STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 607	abuse policy for rep of abuse to the state two-hour timeframe. 2. The facility staff fabuse policy for rep Resident #262's alle (state agency) within timeframe. On 9/23/an allegation of abu #11. The allegation until 9/24/18. On 9/reported an allegatinursing assistant) #reported to the SA unit would be stated to the same abuse of the	ailed to implement the facility orting Resident #3's allegation agency within the required ailed to implement the facility orting Resident #261's and agations of abuse to the SA in the required two-hour 18, Resident #261 reported se to RN (registered nurse) was not reported to the SA 22/18, Resident #262 on of abuse to CNA (certified 9. The allegation was not until 9/24/18. Both allegations ne SA in one FRI (facility	F 607				
	abuse policy for rep of abuse to the state two hour timeframe Resident #3 was ac Resident #3's diagr limited to diabetes, and end stage kidne most recent MDS (r assessment with ar date) of 10/5/18, co as severely impaire The facility policy tic documented, "6. Up concerning a report	ailed to implement the facility porting Resident #3's allegation a gency within the required. Imitted to the facility on 9/2/16. In the second of the facility on 9/2/16. In the second of the facility on 9/2/16. In the second of the facility on 9/2/16. In the faci					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246		A BUILDING	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C		
	ROVIDER OR SUPPLIER		MIN TO THE PROPERTY OF	STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
F 607	following: 6.1 Enter Management Syste allegations involving sexual, mental) not allegation is made A FRI (facility report state agency (Office Certification) on 1/1 Date: 1/17/2019. Residents involved: Injuries: (an X beside Allegation of information regarding documented on the 1/23/19 documente Resident #3) report nursing assistant) viputting me back to around my breast a statement was made when he came to visit with (name of 8 resident #3) stated an investigation was be a lack of educat statement dated 1/1 caring for Resident 1/17/19 documenter son arrived to the breather sexual control of the son arrived to the breather sexual control of the son arrived to the breather sexual control of the sexual control of the breather sexual	or designee will perform the allegation into the Risk m (RMS). 6.2 Report g abuse (physical, verbal, later than two hours after the " ted incident) submitted to the e of Licensure and 8/19 documented, "Incident report date: 1/18/2019. (name of Resident #3). The sincident was FRI. The final report dated d, "On 1/17/19 (name of ed that 'a CNA (certified with red hair was rough when bed, they picked me up and threw me into bed' this let to the resident's son (name) risit(Name of Resident #3's ning arrived to the facility to Resident #3) at this time the rough care to her son. The ned to the resident. (Name of it the CNA threw her into bed. It is initiated and it was found to ion with transfers" A witness 17/19 and signed by the nurse #3 during the evening shift of rid, "Around 6:45 p.m. resident woulding to visit his mom. He	F 60'				
	told him a CNA with threw her in bed. V	se that (name of Resident #3) In red hair grabbed her and When asked the resident what In the son resident stated that:		= II			

PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495246	B. WING_			C 07/2019
NAME OF PROVI	DER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
a C Su ca rea info ca wa will on (mu co on Al: grading #2 co The even the aveca of the ca did co did C	pervisor 3-11 shift lit the DON (director ach. Call placed to formed about incide lit the DON to follow as left at the unit mutness statement signal anager) I received are caring for Resigneering resident in the floor with no in so patient stated the abbed her and threall to (name of ASM ember] #2 [nurse exector of nursing]) and the floor with no interest and the abbed her and threall to (name of ASM ember] #2 [nurse exector of nursing]) and the floor with no interest and the floor with no interest and the floor with no interest and the floor of nursing]) and the floor of nursing her transfer allegation by Resignal and the floor with RN (10 was asked what legation of residen N #10 stated she was affety, separate the rect supervisor. Rotact the director frector if her direct and 2/6/19 at 5:39 p. rector), ASM #2 are	and throw (sic) me in bed. made aware and told me to r of nursing). DON unable to the unit manager and ent and she stated she will wup on this matter. A note anager office to follow up." A gned by the on-call manager ted, "As on call mgr call from facility (name of dent #3) at 7:02 p.m. In room (number) had fallen injuries at about 3:20 p.m. Intat aid with red hair had ew her on the bed. I placed I [administrative staff executive- also known as and after talking with (ASM derview patient in morning fer from wheelchair to bed." If for Resident #3 during the V19, and was made aware of sident #3's son was not w during the survey. In an interview was registered nurse) #10. RN In urses should do if an It abuse is reported to them. It would ensure the patient's staff member and notify her N #10 stated she would of nursing then the executive supervisor was not available. In ASM #1 (the executive and ASM #3 (the clinical quality alse aware of the above	F	607		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y3OC11

Facility ID: VA0279

If continuation sheet Page 46 of 206



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
AND REPORTS		495246	B. WNG	02/0	02/07/2019		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405				
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 607	for reporting alleg	page 46 2 was asked the facility process lations of abuse to the state stated allegations of abuse	F 607			100	
	should be reporte hours. ASM #2 s completed with st report allegations	ed to the state agency within two tated training had recently been aff and they have been told to of abuse to her and ASM #1.			×	A	
	coordinator and u	at ASM #1 was the abuse iltimately needed to know about (Note- not all staff had recently use training).			6		
	No further informa	ation was presented prior to exit.					
	2. The facility state abuse policy for received abuse policy for received abuse policy for received an allegation of a #11. The allegation of a will 9/24/18. On reported an allegation and allegation and policy for reported to the Section 1.	ff failed to implement the facility eporting Resident #261's and allegations of abuse to the SA thin the required two-hour 23/18, Resident #261 reported buse to RN (registered nurse) on was not reported to the SA 9/22/18, Resident #262 ation of abuse to CNA (certified) #9. The allegation was not A until 9/24/18. Both allegations of the SA in one FRI (facility					
	8/24/18. Resider were not limited to and morbid obesi MDS (minimum day Medicare ass (assessment refethe resident #262 was Resident #262 was	as admitted to the facility on the #261's diagnoses included but to arthritis, high blood pressure ty. Resident #261's most recent lata set) (prior to discharge) a 60 sessment with an ARD trence date) of 10/19/18, coded eing cognitively intact. as admitted to the facility on ent #262's diagnoses included					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
		495246	B. WING_		0:	2/07/2019	
	NT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 607	Continued From pale but were not limited depressive disorder #262's most recent (prior to discharge) assessment with an date) of 12/18/18, cas moderately impart the facility policy tit documented, "6. Up concerning a report abuse, mistreatment executive directory following: 6.1 Enter Management System allegations involving sexual, mental) not allegation is made. A FRI (facility report state agency (Office Certification) on 9/2 date: September 2 and 9/22/18. Resident #261 [9/2 #262 [9/23/18]). In	ge 47 Ito paralysis, major and diabetes. Resident MDS (minimum data set) a 14 day Medicare ARD (assessment reference oded the resident's cognition aired. Itled, "Abuse Prohibition" for neceiving information of suspected or alleged at, or neglect, the CED (center or designee will perform the allegation into the Risk am (RMS). 6.2 Report g abuse (physical, verbal, later than two hours after the " Ited incident) submitted to the		DEFICIENCY)			
	taken: (name of Re asked the aide on the bedpan. She swas not positioned was left to 'soil all the bedpan not postated that she was on the bedpan, pubedpan since patie advised the CNA to	including location and action esident #261) reported that she 11-7 shift 9/20/18 to put her on stated she advised the aide she correctly on the bedpan and over herself and the bed' due to esitioned correctly. She also is 'rough' while positioning her shing her hard to get her on the ent was unable to assist. She hat she was uncomfortable					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIP	LE CONSTRUCTION	COMPLETED	
		495246	B. WING		C 02/07/2019
	ROVIDER OR SUPPLIER	A WEST AND A STATE OF THE STATE		STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE COMPLETION
F 607	Resident #262) advithe 11-7 aide on 9/2 changing her diaper 'pushing and pulling asked the aide rolled herovide care. (Nam to state the aide gragetting her comfortate pain due to that being A witness statement 9/23/18 documented concerned (sic). Or 2018 at 3:30 p.m. who with the supervision of CNA #9 to the situation. So I then #10) Sunday morning A witness statement documented, "To who fon the concerned (sic) and had wet on incident to the charge #11) who told me should be situation. So I then #10) Sunday morning A witness statement documented, "To who fon the supervisor. I had times during the ship about the incident a anyone else about in the supervisor.	On the same date, (name of ised nursing supervisor that 2/18 used 'force' when . Patient stated the aide was me so hard and rough.' She op due to the aide hurting her ner eyes and continued to e of Resident #262) went on abbed her right leg while able in bed which caused her nigher 'bad leg." It signed by CNA #9 on d, "To Whom It may a Saturday September 22, when I went into (Resident exported to me that the 11-7 care to her was very rude and extrow (sic) the diapers on the er names and was upset anable to reached (sic) the call herself. So I reported the ged (sic) nurse (name of RN ne could not deal with the reported it to (name of RN ne on the 7-3 shift." It signed by RN #11 on 9/23/18 hom this may concern, (name about an encounter related to ame of Resident #262). It is stated that I told her I could a now and that she should tell ad seen the resident several iff later on but I had forgotten and did not ask the resident or it."	F 60		
	A witness statemen	t documented by RN #10 on			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO.	MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		495246	B. WING			02/07/2019	
NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER		11 DA	ET ADDRESS, CITY, STATE, ZIP COI AIRY LANE DERICKSBURG, VA 22405	DE			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 607	shift on Sunday 9 reported to me the 9/22/2018) by (not (number) that the night 11-7 9/21/20 rough with her, the (sic) ever had to said she reported she said she tried 3-11 Saturday whout (name of RN of CNA #9) was time to deal with she gave a recoll from the night of statement to the director of nursin the charge nurse (sic) admission. throughout the sl sleeping peaceful were no concern	page 49 Inted, "At the start of my 7am I/23/2018, (name of CNA #9) I at she was told last night (3-11 I ame of Resident #262) in Room I CNA the night before (Friday I on the most abusive person shes I deal with. (Name of CNA #9) I it to me this morning because I to notify (name of RN #11) on I nen the patient reported it to her, I ment the patient reported it to her, I ment (sic) too busy and don't have I that.' Upon interviewing patient, I ection of her account of events I the concern. I forwarded her I unit Manager, ADON (assistant I g) for her assigned unit. I was I rounded multiple times I rounded multiple times I for the most part, patient was I selly so I did not wake her. There I se reported to me throughout the I need to work with her, nor did the	F 607				
	#262 by RN #10 here Friday night the night was very was pissed off be attitude and slam used force when She was pushing rough. I asked h me and she rolle she was done. I was cold and sca	ssues to me." ally obtained from Resident on 9/23/18 documented, "I came t and the CNA in the middle of ry rough with me. I knew she ecause she came in with an amed the closet door. She also she was changing my diaper. g and pulling me so hard and her to stop because it was hurting d her eyes and kept doing it until Her attitude and body language ary. Please don't make me have again, I am scared to be around		•	42	14 1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246		(X2) MULTI A. BUILDIN B. WING _	PLE CONSTRUCTION G	COME	(X3) DATE SURVEY COMPLETED C 02/07/2019		
British British		ROVIDER OR SUPPLIER ONT CENTER					
	(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	F 607	comfortable in bed it is my bad leg. S She threw a pack to the empty bed of	age 50 my right leg while getting me I and it was so painful because the isn't a nice or gentle person. of my diapers across the room on the other side of the room. or talk to me much, Real	F 6	07		
		anything I said. I the happened to one of	Didn't seem to acknowledge inally decided to report what of the girls last night because I the other people here safe				
		by RN #10 on 9/2: reported to this nu nights ago was ve said she reported same shift and asl question doesn't g the nurse told her doesn't go back to	at obtained from Resident #261 B/19 documented, "Patient rse that a CNA she had a few ry rude and hurtful for her. She it to her nurse around 6am that ked the nurse that the CNA in o back in the room again, and she would make sure that CNA her room. Patient said the a nasty attitude and seemed	==			
		like she didn't real she seemed very anything she picke somewhere or put very rough and ab put on a bedpan be positioned right, be she was forced to because the bedp Patient also stated her while positioni CNA that the side	ly like her job. Also stated that angry and was throwing things, ed up and needed to place down, she threw it and was rupt. Patient stated she was y CNA and told her it wasn't ut she left patient that way and soil all over herself and the bed an was not positioned correctly. It that she was very rough with ng her on the bedpan. She told she was laying on restricted her e couldn't help the CNA with				
		repositioning her, really hard to get I to, and it wasn't co	however she pushed patient her in the position she wanted omfortable during the whole asked to never have the CNA in				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER: A. BUILDING _		COM	(X3) DATE SURVEY COMPLETED C	
		495246	B. WNG _	B. WING		2/07/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 607	(name), an agend nurse as the one couldn't remember as the one couldn't remember as the one documented, "Referenced that she 9/20/18 to put he advised the aide on the bedpan are and the bed' due correctly. She all while positioning hard to get her or unable to assist, was unable to as was uncomfortable same date, (namnursing supervised stated the aide whard and rough." to the aide hurtin eyes and continuenced the sident #262) wher right leg while which caused he leg." CONCLUST	ain. She described the CNA as by CNA. She described her she has every night almost, but	F 60		Y)		
	orient (sic) reside perpetrator with a during ADL (active Accused employ- accused employ- residents (sic) co- rough. She state	e to interviewed Staff, alert and ents in the care of alleged no allegations of roughness rities of daily living) care. ee denies allegations. Per ee states she was not aware of encern and voicing she was es she forgot her hearing aids the contract agency and					

PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE : COMPI	
	Salve	495246	B WING		V ₂	02/0	7/2019
	ROVIDER OR SUPPLIER	1173 C =	•	1	TREET ADDRESS, CITY, STATE, ZIP CODE I DAIRY LANE REDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	on the 'Abuse policy at the Center Nursing Einesident: Stable." On 2/6/19 at 3:37 p.m conducted with CNA: CNA should do if a reallegation of abuse, Consupposed to report it asked if she does any allegation to the charmal follow up to see if she not, I report to the surfollow up to see if she not, I report to the surfollow up to see if she not, I report to the surfollow up to see if she not, I report to the surfollow up to see if she not, I report to the surfollow up to see if she not, I report to the surfollow up to see if she not, I report to the surfollow up to see if she not, I report to the surfollow up to see if she not, I report to the surfollow up to see if she not, I report to the surfollow up to see if she not, I report to the surfollow up to stated she as was wrong, and the report. The not of the surfollow up to stated she up to the facility of the surfollow up to stated she was not in the building she came to the facility of the surfollow up to see if she not, I report to the surfollow up to see if she not, I r	at Facility. Staff in service and Abuse Prohibition' with executive. Current Status of the country of the count	F	607			
		N#10 stated she would If nursing then the executive					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y3OC11

Facility ID: VA0279

If continuation sheet Page 53 of 206



		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) I A. BU		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495246	8. WING		02/07/2019	
	ROVIDER OR SUPPLIER		11	REET ADDRESS, CITY, STATE, ZIP CODE DAIRY LANE REDERICKSBURG, VA 22405	1 020172010	
(X4) ID PREFIX TAG	(EACH DEFICI	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION	
F 607	RN #10 was asker regarding Resider stated she made sinterviewed the recontacted the ADO nursing) as soon a allegation. On 2/6/19 at 5:39 director), ASM #2 specialist) were moncern. (Note-A employed at the fa ASM #2 was asker reporting allegation ASM #2 stated all reported to the state ASM #2 stated the completed with streport allegations ASM #2 stated the coordinator and urany allegations. (been provided about 10 or 2/7/19 at 9:22 conducted with R should be done if resident's allegati "Right away you a supervisor and the manager." When this should be done if the sh	at supervisor was not available. It to explain the situation at #262's allegation. RN #10 sure Resident #262 was okay, sident, interviewed staff and DN (assistant director of as she was made aware of the ap.m., ASM #1 (the executive and ASM #3 (the clinical quality ade aware of the above asM #1 and ASM #2 were not acility in September 2018). It is a facility process for an of abuse to the state agency agations of abuse should be atteragency within two hours. It is and they have been told to of abuse to her and ASM #1. It is at ASM #1 was the abuse atteragency in a staff had recently use training). It is a saked what she is made aware of a con of abuse. RN #11 stated, are supposed to tell your asked about the period of time asked abou	F 607	DEFICIENCY		
	should be reporte RN #11 was aske regarding Reside	n 24 hours but the allegation d to the supervisor right away. d to explain the situation nt #262's allegation. RN #11 ne to her and stated Resident				

Annual Control of the	MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246 (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		CC	(X3) DATE SURVEY COMPLETED C 02/07/2019		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (11 DAIRY LANE FREDERICKSBURG, VA 22405		20172013
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO ' DEFIC!ENG	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 609 SS=D	#262 reported and did not occur on hatell the supervisor. No further informate Reporting of Allege CFR(s): 483.12(c) In respondent and the supervisor. §483.12(c) In respondent and the supervisor and misappare reported immethours after the allegations bodily injurt the events that cause the allegations bodily injurt the administrator of the administrator of the administrator of the administrator of adult protective serior jurisdiction in loaccordance with Starvey Agency, with incident, and if the appropriate corrections.	allegation but the alleged event er shift so she told the CNA to tion was presented prior to exit. ed Violations (1)(4) onse to allegations of abuse, on, or mistreatment, the facility ture that all alleged violations eglect, exploitation or iding injuries of unknown propriation of resident property, diately, but not later than 2 gation is made, if the events gation involve abuse or result in y, or not later than 24 hours if use the allegation do not involve esult in serious bodily injury, to f the facility and to other to the State Survey Agency and vices where state law provides ing-term care facilities) in late law through established	F 603	1. Resident #3, 261 facility failed to i facility abuse pol allegations were upon Administra notification. 2. All residents in the risk. 100% of cur who are alert and were interviewed management sta potential abuse to all allegations had reported and involutional accordingly. 3. Nurse Practice Ed designee in-servi staff on Abuse Porequirement to r immediately to so management. Poto ensure that st that the regulations to within two hours	mplement licy. Abuse submitted ation he facility are at rrent residents d oriented d by aff regarding to ensure that ave been restigated ducator and or iced 100% of olicy, to include report abuse senior olicy reviewed aff understand on is to report the state	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495246	B. WNG_	Silve	C 02/07/2019	
111111	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 609	and clinical record at the facility staff faile abuse to the SA (st. manner for three of sample, Residents: 1. The facility staff fallegation of abuse timeframe. Resider reported to staff on to the SA until 1/18/ 2. The facility staff for the SA within the Resident #261's and Resident to the SA within the Resident #261's allegation of 9/23/18 a until 9/24/18. Reside was reported to the SA until 9/24/18. Reside was reported to the SA until 9/24/18. Resident #3 was addreported incident) on The findings include 1. The facility staff fallegation of abuse of timeframe. Resident to the SA until 1/18/18. Resident #3 was addreported to staff on to the SA until 1/18/18 resident #3 was addresident #3's diagnolimited to diabetes, rand end stage kidner most recent MDS (massessment with an	review, facility document review review, it was determined that ad to report allegations of ate agency) within a timely 55 residents in the survey #3, #261 and #262. railed to report Resident #3's to the SA within the two-hour nt #3's allegation of abuse was 1/17/19 and was not reported 19. railed to report Resident at #262's allegations of abuse two-hour timeframe. regation of abuse was reported and was not reported to the SA rent #262's allegation of abuse fron 9/22/18 and was not rentil 9/24/18. Both allegations are SA in one FRI (facility in 9/24/18.	F 60	4. Resident Council will m weekly x 4 weeks with emphasis on appropriate treatment and resident Social Services and /or Director will interview residents weekly for for and randomly thereafte ensure appropriate treand freedom from abuse/mistreatment. Frabuse allegations will be reviewed by the Admin Director of Nursing, or immediately. Variances corrected immediately reviewed at Quality Assand Performance Improfis	te t abuse. Activities 10 ur weeks er to atment urther e istrator, designee s will be and surance ovement	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DNSTRUCTION	СОМІ	SURVEY PLETED	
		495246	B. WING		- 10 miles	SALLS WEATHER	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405				
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 609	Continued From p		F 609		a vani v a oj	3-14	
	state agency (Offi Certification) on 1 Date: 1/17/2019. Residents involve	orted incident) submitted to the ce of Licensure and /18/19 documented, "Incident Report date: 1/18/2019. d: (name of Resident #3).					
	beside Allegation information regard	oide No). Incident type: (an X of abuse/mistreat)." No further ling the incident was the FRI. The final report dated					
	1/23/19, documen Resident #3) repo nursing assistant) putting me back to around my breast	ted, "On 1/17/19 (name of rted that 'a CNA (certified with red hair was rough when bed, they picked me up and threw me into bed' this					
	when he came to son) later than even visit with (name of resident reported charge nurse retu (name of son) to it Resident #3) state	ride to the resident's son (name) visit(Name of Resident #3's ening arrived to the facility to f Resident #3) at this time the rough care to her son. The rned to the resident's room with interview the resident. (Name of ed the CNA threw her into bed.				8 5	
	be a lack of educa statement dated 1 caring for Resider 1/17/19 document	vas initiated and it was found to ation with transfers" A witness /17/19 and signed by the nurse at #3 during the evening shift of ted, "Around 6:45 p.m. resident					
	reported to this nu told him a CNA wi threw her in bed.	building to visit his mom. He urse that (name of Resident #3) th red hair grabbed her and When asked the resident what	4				
	a CNA grab (sic) I Supervisor 3-11 s call the DON (dire reach. Call place	of the son resident stated that: me and throw (sic) me in bed. hift made aware and told me to ector of nursing). DON unable to d to the unit manager and cident and she stated she will					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495246	B. WNG_		1	C /07/2019
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405			0112010
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 609	was left at the unit witness statement on 1/17/19 docum (manager) I receiv nurse caring for Reconcerning resider on the floor with nealto patient stated grabbed her and the call to (name of AS member] #2 [nurse director of nursing #2) we decided to concerning her trail. The nurse who can evening shift on 1/2 the allegation by Favailable for intervious asked what allegation of resident to the context with RI #10 was asked what legation of resident RN #10 stated she safety, separate the direct supervisor. Contact the direct director if her direct on 2/6/19 at 5:39 director), ASM #2 specialist) were medical statement.	low up on this matter. A note manager office to follow up." A signed by the on-call manager ented, "As on call mgr ed call from facility (name of esident #3) at 7:02 p.m. In the in room (number) had fallen on injuries at about 3:20 p.m. In that aid with red hair had have her on the bed. I placed of a fallen injuries at about 3:20 p.m. In that aid with red hair had have her on the bed. I placed of a fallen injuries at about 3:20 p.m. In that aid with red hair had have her on the bed. I placed of a fallen injuries at about 3:20 p.m. In that aid with red hair had have her on the bed. I placed of a fallen injuries at about 3:20 p.m. and after talking with (ASM interview patient in morning insfer from wheelchair to bed." I that aid with red hair had have her on the bed. I placed of a fallen injuries a desident #3 during the 17/19, and was made aware of a fallen injuries. In the survey. I that aid with red hair had have her on the bed. I placed of a fallen injuries a fallen injuries and have a fallen injuries. In the survey. I that aid with red hair had have her on the bed. I placed on the survey. I that aid with red hair had have her on the bed. I placed on the survey. I that aid with red hair had have her on the bed. I placed on the survey. I that aid with red hair had fallen on the bed. I placed on the bed. I placed on the survey. I that aid with red hair had fallen on the survey. I that aid with red hair had fallen on the survey. I that aid with red hair had fallen on the survey. I that aid with red hair had fallen on the survey. I that aid with red hair had fallen on the survey. I that aid with red hair had fallen had fallen on the survey. I that aid with red hair had fallen	F 6			
	for reporting alleg- agency. ASM #2 should be reporte	was asked the facility process ations of abuse to the state stated allegations of abuse d to the state agency within two lated training had recently been				

AND PLAN OF CORRECTION IDENTIFICATI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 495246	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL 11 DAIRY LANE FREDERICKSBURG, VA 22405	02/07/2019 DE
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION DATE
F 609	report allegations of ASM #2 stated that coordinator and ultimate any allegations. (Note that the facility policy to the facility policy polic	f and they have been told to f abuse to her and ASM #1. ASM #1 was the abuse mately needed to know about ote- not all staff had recently se training). Itled, "Abuse Prohibition" on receiving information of suspected or alleged at, or neglect, the CED (center or designee will perform the allegation into the Risk em (RMS). 6.2 Report g abuse (physical, verbal, later than two hours after the	F 609		
	2. The facility staff #261's and Reside to the SA within the Resident #261's all to staff on 9/23/18 until 9/24/18. Resi was reported to the SA were submitted to reported incident) of Resident #261 was 8/24/18. Resident were not limited to and morbid obesity MDS (minimum day Medicare asset (assessment refered).	failed to report Resident int #262's allegations of abuse two-hour timeframe. egation of abuse was reported and was not reported to the SA dent #262's allegation of abuse iff on 9/22/18 and was not until 9/24/18. Both allegations he SA in one FRI (facility			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495246	B. WNG			
	NT CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405		02/07/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETION	
F 609	12/11/11. Resident abut were not limited depressive disorder #262's most recent for (prior to discharge), assessment with an date) of 12/18/18, coas moderately impair A FRI (facility reported state agency (Office Certification) on 9/24 date: September 24, and 9/22/18. Resident #261 [9/20/20/20/20/20/20/20/20/20/20/20/20/20/	admitted to the facility on #262's diagnoses included to paralysis, major and diabetes. Resident MDS (minimum data set) a 14 day Medicare ARD (assessment reference ded the resident's cognition red.	F 60			
	Resident #262) advi the 11-7 aide on 9/2 changing her diaper 'pushing and pulling asked the aide to sto and the aide rolled h	sed nursing supervisor that 2/18 used 'force' when Patient stated the aide was me so hard and rough.' She op due to the aide hurting her eyes and continued to a of Resident #262) went on	E)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246		(X2) MULTIF A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 02/07/2019	
	NT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405	
(X4) ID PREFIX TAG	(EACH DEFICIE!	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE COMPLETION
F 609	getting her comforts pain due to that bei A witness statemen 9/23/18 documente concerned (sic). O 2018 at 3:30 p.m. w #262's room) she recan who had given abusive to her. She other bed, calling hecause she was u bell and had wet or incident to the char #11) who told me sistuation. So I then #10) Sunday morni A witness statement documented, "To w of CNA #9) told me her by a resident (recommended with it right the supervisor. I had times during the shabout the incident a anyone else about	abbed her right leg while able in bed which caused her right leg." It signed by CNA #9 on d, "To Whom It may a Saturday September 22, when I went into (Resident eported to me that the 11-7 care to her was very rude and the throw (sic) the diapers on the er names and was upset anable to reached (sic) the call a herself. So I reported the ged (sic) nurse (name of RN he could not deal with the reported it to (name of RN and on the 7-3 shift." It signed by RN #11 on 9/23/18 hom this may concern, (name about an encounter related to the lame of Resident #262), stated that I told her I could the lad seen the resident several and did not ask the resident or	F 60		
	shift on Sunday 9/2 reported to me that 9/22/2018) by (nam (number) that the 0 night 11-7 9/21/201 rough with her, the	ed, "At the start of my 7am (3/2018, (name of CNA #9) she was told last night (3-11 ne of Resident #262) in Room (2NA the night before (Friday 8) was being very rude and most abusive person shes eal with. (Name of CNA #9)			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	E CONTRACTOR OF THE PARTY OF TH	PLE CONSTRUCTION 3		OMPLETED
		495246	B. WING	11 1770/302		C 02/07/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 609	she said she tried to 3-11 Saturday when but (name of RN #1 of CNA #9) was 'Im time to deal with that she gave a recollect from the night of the statement to the Undirector of nursing) the charge nurse on (sic) admission. I rothroughout the shift, sleeping peacefully were no concerns reshift I was assigned CNA report any issue A statement verbally	to me this morning because notify (name of RN #11) on the patient reported it to her, 1's) response back to (name (sic) too busy and don't have t.' Upon interviewing patient, ion of her account of events concern. I forwarded her it Manager, ADON (assistant for her assigned unit. I was 11-7, the night of patients bunded multiple times for the most part, patient was so I did not wake her. There exported to me throughout the to work with her, nor did the less to me."	F 60	09		
	#262 by RN #10 on here Friday night and the night was very man pissed off becautitude and slammer used force when she was pushing and rough. I asked her me and she rolled his he was done. Her was cold and scary, to deal with her again her. She grabbed in comfortable in bed at it is my bad leg. She she threw a pack of to the empty bed or She didn't speak or grumpy and quiet.	9/23/18 documented, "I came of the CNA in the middle of ough with me. I knew she use she came in with an ed the closet door. She also e was changing my diaper. In the property of the closet door was hard and to stop because it was hurting er eyes and kept doing it until attitude and body language. Please don't make me have in, I am scared to be around my right leg while getting me and it was so painful because e isn't a nice or gentle person. If my diapers across the room is the other side of the room. It talk to me much, Real Didn't seem to acknowledge nally decided to report what				

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPE A. BUILDING B. WING	E CONSTRUCTION		PLETED C	
NAME OF P	ROVIDER OR SUPPLIER	495246	B. WING	STREET ADDRESS, CITY, STATE, ZIP C		/07/2019	
	NT CENTER			11 DAIRY LANE FREDERICKSBURG, VA 22405	I DAIRY LANE		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 609	need to help keep too." A patient statemer by RN #10 on 9/2: reported to this nu nights ago was ve said she reported same shift and as question doesn't go back to CNA came in with like she didn't real she seemed very anything she picke somewhere or put very rough and abput on a bedpan be positioned right, be she was forced to because the bedp Patient also stated her while positioning CNA that the side movement and she repositioning her, really hard to get to, and it wasn't coprocess. Patient	of the girls last night because I the other people here safe and obtained from Resident #261 and 3/19 documented, "Patient arse that a CNA she had a few ary rude and hurtful for her. She it to her nurse around 6am that ked the nurse that the CNA in go back in the room again, and she would make sure that CNA the room. Patient said the a nasty attitude and seemed ally like her job. Also stated that angry and was throwing things, and up and needed to place to down, she threw it and was brupt. Patient stated she was by CNA and told her it wasn't that she left patient that way and soil all over herself and the bed arn was not positioned correctly. If the the couldn't help the CNA with however she pushed patient her in the position she wanted omfortable during the whole asked to never have the CNA in	F 60				
	(name), an agence nurse as the one couldn't remembe A final report sent documented, "Re	ain. She described the CNA as by CNA. She described her she has every night almost, but er her name." I to the SA on 9/27/18 sident (name of Resident #261) asked the aide on 11-7 shift	le				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C			
		495246	B. WING		-1 8	0	2/07/2019	
	ROVIDER OR SUPPLIER			11 DAIRY LAN	STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECEACH CORRECTIVE ACTION SHOOSS-REFERENCED TO THE APPLICATION OF T	OULD BE	(X5) COMPLETION DATE	
F 609	advised the aide is on the bedpan and and the bed' due to correctly. She als while positioning hard to get her on unable to assist. was unable to assist was uncomfortabl same date, (name nursing supervisoused 'force' when stated the aide was hard and rough.' to the aide hurting eyes and continue Resident #262) wher right leg while which caused her leg." CONCLUS allegation of abus unsubstantial due orient (sic) reside perpetrator with no during ADL (activity Accused employersidents (sic) corough. She state day of the incider is no longer work on the 'Abuse pol the Center Nursir Resident: Stable.	on the bedpan. She stated she the was not positioned correctly discovered was left to 'soil all over herself to the bedpan not positioned to stated that she was 'rough' there on the bedpan, pushing her the bedpan since patient was She advised the CNA that she dist with positioning and that she elected with positioning and that she elected the disternance of the process. On the elected of Resident #262) advised of that the 11-7 aide on 9/22/18 changing her diaper. Patient as 'pushing and pulling me so She asked the aide to stop due of the her and the aide rolled her elected to provide care. (Name of the elected to provide care. (Name of the elected to the pain due to that being her 'bad ON: Unable to Substantiate the Allegations to be to interviewed Staff, alert and that in the care of alleged to allegations of roughness the denies allegations. Per the states she was not aware of the cern and voicing she was she forgot her hearing aids the latt. CNA is contract agency and the gas she forgot her hearing aids the latt. CNA is contract agency and lang at Facility. Staff in service icy and Abuse Prohibition' with the general states of the current Status of the pump of the provide current Status of the pump.	F	609				
	conducted with C	NA #9. When asked what a						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246		(X2) MULTIP A. BUILDING B. WING	LE CONSTRUCTION	СОМ	E SURVEY PLETED C	
	ROVIDER OR SUPPLIER	453240	J. VIIIC	STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405		/07/2019
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 609	supposed to report asked if she does allegation to the chrollow up to see if not, I report to the #9 stated she wou allegation occurred shift. CNA #9 was regarding Residen CNA #9 stated on #262's room and the CNA #9 stated she was wrong, and the p.m. to 7:00 a.m. s and said verbal thi place. CNA #9 stated this place. CNA #9 stated she was wrong, and the p.m. to 7:00 a.m. s and said verbal this place. CNA #9 stated the place. CNA #9 stated the place. CNA #9 stated the stated to the stated the stated that t	e, CNA #9 stated, "I am it to the charge nurse." When anything after she reports the barge nurse, CNA #9 stated, "I she does anything about it. If supervisor above her." CNA Id follow up the next day if the If on her 3:00 p.m. to 11:00 a.m. asked to explain the situation to #262's allegation of abuse. 19/22/18 she went into Resident the resident did not look happy. The asked Resident #262 what the resident explained the 11:00 Thift CNA had thrown a diaper the she went straight to RN If the information reported to 16.62. CNA #9 stated RN #11 supervisor but the supervisor ding so she told RN #10 when	F 60			
	conducted with RN #10 was asked wh allegation of reside RN #10 stated she safety, separate the direct supervisor. contact the director if her direct RN #10 was asked regarding Residen stated she made separated the resecontacted the ADC	c.m., an interview was at rurses should do if an an an abuse is reported to them. It would ensure the patient's e staff member and notify her RN #10 stated she would or of nursing then the executive at supervisor was not available. If to explain the situation to t#262's allegation. RN #10 are Resident #262 was okay, sident, interviewed staff and DN (assistant director of as she was made aware of the				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED C
		495246	B. WING_		02/07/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION
F 609	Continued From pag On 2/6/19 at 5:39 p.	ge 65 m., ASM #1 (the executive	F 60	09	
	specialist) were made concern. (Note- ASI employed at the faci ASM #2 was asked reporting allegations ASM #2 stated alleg reported to the state ASM #2 stated training completed with staff report allegations of ASM #2 stated that a coordinator and ultimeters.	and ASM #3 (the clinical quality de aware of the above M #1 and ASM #2 were not dility in September 2018). The facility process for sof abuse to the state agency against of abuse should be agency within two hours, and they have been told to abuse to her and ASM #1. ASM #1 was the abuse mately needed to know about ote- not all staff had recently e training).			
	conducted with RN should be done if sh resident's allegation "Right away you are supervisor and the smanager." When as this should be done, done timely within 2 should be reported t RN #11 was asked t regarding Resident stated a CNA came #262 reported an all	m., an interview was #11. RN #11 was asked what he is made aware of a of abuse. RN #11 stated, e supposed to tell your supervisor must tell the sked about the time period , RN #11 stated it must be 4 hours but the allegation to the supervisor right away. to explain the situation #262's allegation. RN #11 to her and stated Resident legation but the alleged event shift so she told the CNA to			
F 622 SS=D			F 6:	22	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _ B. WING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 02/07/2019		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION		
	§483.15(c) Transferes §483.15(c)(1) Facility must remain in the facility must remain in the facility discharge the reside (A) The transfer or resident's welfare a cannot be met in the (B) The transfer or because the reside sufficiently so the reservices provided by (C) The safety of in endangered due to status of the resident (D) The health of in otherwise be endand (E) The resident has appropriate notice, under Medicare or Monpayment applies submit the necessary payment or after the Medicare or Medicar esident refuses to president who become admission to a facility resident only alloward or (F) The facility cease (ii) The facility may resident while the aps § 431.230 of this charge notice froid 431.220(a)(3) of this	r and discharge- ity requirements- permit each resident to y, and not transfer or ent from the facility unless- discharge is necessary for the and the resident's needs e facility; discharge is appropriate nt's health has improved esident no longer needs the y the facility; dividuals in the facility is the clinical or behavioral nt; dividuals in the facility would gered; s failed, after reasonable and to pay for (or to have paid Medicaid) a stay at the facility. Is if the resident does not ry paperwork for third party e third party, including id, denies the claim and the pay for his or her stay. For a nes eligible for Medicaid after dy, the facility may charge a ble charges under Medicaid;	F 622	1. Resident 208, 90, and 51 transferred to the hospit without required documentation. 2. All residents being transfer to the hospital are at risk Facility has not been send documentation according regulation to hospital on transfers. 3. Nurse Practice Educator, or designee to in-service licensed nursing staff on documentation that is rewhen sending a resident hospital. 4. ADON or designee to audischarged residents' chaweek for 4 weeks, then we thereafter, to ensure prodocumentation is sent. Variances will be corrected brought to Quality Assura and Performance Improve Committee monthly, with QAPI Committee responsifor ongoing compliance. 5. Date of Compliance: 3/15, 200.	ferred c. ding g to ADON quired to the lit arts 5 X yeekly aper ed and ance ement the ible		

PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT C AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE S COMPL	
		495246	B. WING_			02/0	;)7/2019
	ROVIDER OR SUPPLIER			11	TREET ADDRESS, CITY, STATE, ZIP CODE 1 DAIRY LANE REDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	•	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 622	facility. The facility in that failure to transfer \$483.15(c)(2) Docum When the facility transesident under any or in paragraphs (c)(1)(section, the facility more discharge is documedical record and a communicated to the institution or provider (i) Documentation in must include: (A) The basis for the (i) of this section. (B) In the case of pasection, the specific be met, facility atterneeds, and the servifacility to meet the new (ii) The documentation (2)(i) of this section in (A) The resident's produced in the communication of (B) A physician when necessary under part this section. (iii) Information provimust include a minimust	ent or other individuals in the flust document the danger or or discharge would pose. Inentation. Insfers or discharges a fight the circumstances specified i)(A) through (F) of this flust ensure that the transfer mented in the resident's appropriate information is a receiving health care or the resident's medical record transfer per paragraph (c)(1) aragraph (c)(1)(i)(A) of this resident need(s) that cannot flust to meet the resident ce available at the receiving flust to meet the resident ce available at the receiving flust be made by any sician when transfer or flust be made by any sician when transfer or flust and in transfer or discharge is regraph (c)(1)(i)(C) or (D) of fluided to the receiving provider flum of the following: ion of the practitioner flust or information including the information including t	F	322			
	(D) Ali special instru	ctions or precautions for					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y3OC11

Facility ID: VA0279

If continuation sheet Page 68 of 206



RECEIVED

495246 B. WNG 02/0	07/2019	
NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405	2/07/2019	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST 8E PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 622 Continued From page 68 ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge surmary, consistent with \$483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to evidence that required documentation was sent with residents to the Hospital at the time of transfer, for three of 55 residents, Residents #208, #90, and #51. 1. The facility staff failed to evidence that Resident #208's comprehensive care plan goals were sent with the resident to the hospital at the time of the facility-initiated transfer on 05/25/2018. 2. The facility staff failed provide required documentation to a receiving provider for Resident #90's facility initiated hospital transfer dated 11/28/18 and 1/5/18. 3. The facility staff failed to provide evidence that all required information, special instructions for ongoing care, advance directives and comprehensive care plan goals) was provided to the hospital staff when Resident #51 was transferred to the hospital on 1/24/19. The Findings Included: 1. The facility staff failed to evidence that		

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		495246	B. WING_		ABW S		02/07/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 622	Continued From	page 69	F	622			
	were sent with the	comprehensive care plan goals e resident to the hospital at the r-initiated transfer on					
	Resident #208 was 05/04/2018. Her fracture, muscle	as reviewed as a closed record. as admitted to the facility on diagnoses included right hip weakness, hyperlipidemia (high					
	hypertension (hig recent Minimum I was a Medicare Assessment Refe 05/16/2018. Resi	esterol in the blood), and the blood pressure). Her most Data Set (MDS) Assessment 14 Day Assessment with and therence Date (ARD) of dent #208 was scored as a six					
	(BIMS), indicating #208 was coded assistance of two and bed mobility;	nterview for Mental Status g severe impairment. Resident as requiring extensive or more people for transfers and extensive assistance of one ation, dressing, eating, hygiene,					(#)
	revealed that Rethe hospital on 0 nurse's note date Resident #208 w room at 5:45 p.m	dent #208's closed record sident #208 was transferred to 5/25/2018. According to the ed 05/25/2018 8:59 p.m., as discovered on the floor of her a. Resident #208 complained of					
	notified the Provi of the right hip. I- note, Resident # informed of the fi mother to be ser immediately. A re revealed an orde "Send Resident"	hip at that time. Facility staff ider, who ordered a mobile x ray flowever, according to the nurse's 208's daughter, upon being all, stated she wished for her at to the ER (emergency room) eview of the Physician's Orders of the O5/25/2018 reading to [HOSPITAL] ER for Tx Eval (evaluation) per family					8

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION		TE SURVEY MPLETED
		495246	B. WNG	10% AUSD 125 325 11 11	C	2/07/2019
	ROVIDER OR SUPPLIER		STF 11 I FR	720172013		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 622	Continued From pa	age 70	F 622			
	05/25/2019 revealed	of the nurse's notes for ed no description of what any, was sent to the hospital 3.				
	(Administrative Sta Director, and ASM Executive, were in	Meeting on 02/06/2019, ASM If Member) #1, the Executive #2, the Center Nurse formed of the concerns t #208's transfer, and were	A .			
	asked to provide d with her to the hos usually give a face demographics, his	ocumentation of what was sent pital. ASM #2 replied, "We sheet with the resident's tory and physical and also ory tests results]. We also				
	have a transfer for documents that we months ago, howe consistently." ASM evidence that Resi care plan goals we	m with a list of required estarted to use a couple of ver, nursing is not using it #2 was asked if the facility had dent #208's comprehensive re provided to the hospital for hospital transfer on 05/25/18.				
	The facility staff documentation to a	tion was provided prior to exit. failed provide required a receiving provider for ility initiated hospital transfer d 1/5/18.				
e e	10/23/18 with a mo 1/10/19. Diagnose	admitted to the facility on out of recent readmission date of sincluded but were not limited ollapse (1), depression, urinary bradycardia (2).				
	Medicare fourteen	IDS (minimum data set), a day assessment, with an ARD ence date) of 1/24/19 coded				

PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 622 Continued From page 71 the resident as having a score of five on the BIMS (brief interview for mental status), indicating the resident had severe cognitive impairment.		DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE COMPI	.ETED
WOODMONT CENTER 11 DAIRY LANE FREDERICKSBURG, VA 22405			495246	B. WING_				1
PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 622 Continued From page 71 the resident as having a score of five on the BIMS (brief interview for mental status), indicating the resident had severe cognitive impairment.					11 DAIRY LANE	CODE		-
the resident as having a score of five on the BIMS (brief interview for mental status), indicating the resident had severe cognitive impairment.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI)	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BI THE APPROPRIA		(X5) COMPLETION DATE
Resident #90's clinical record revealed that she was sent to the hospital on 11/28/18. A nurse's note dated 11/28/18 at 3:31 p.m., documented "(name of resident) had an unplanned transfer. Contact person notified of transfer." Resident #90's clinical record revealed that she was sent to the hospital on 1/5/19. Nurse's note dated 1/5/19 at 7:18 p.m., documented "This writer F/U (followed up) with (name of hospital) on pt. (patient) status and noted resident admitted with diagnosis of AMS (altered mental status) and acute cystitis (urinary tract infection)." There was no evidence in the clinical record that the required information was provided to the hospital for Resident #90's facility initiated hospital transfers dated 11/28/18 and 1/5/18. On 02/07/19 at approximately 11:18 a.m., an interview was conducted with ASM (administrative staff member) #2, the Nurse Executive. ASM #2 was asked what documents the facility provides to receiving providers when a resident is transferred to the hospital. ASM #2 replied, "We usually give a face sheet with the resident's demographics, history and physical and also some labs [laboratory tests results]. We also have a transfer form with a list of required documents that we started to use a couple of months ago, however, nursing is not using it consistently." ASM #2 was asked if the facility had evidence that the required documentation such as but not limited to: Contact information of the residents, resident representative information of	F 622	the resident as having (brief interview for me resident had severe of Resident #90's clinical was sent to the hospinote dated 11/28/18 a "(name of resident) he Contact person notifical Resident #90's clinical was sent to the hospidated 1/5/19 at 7:18 writer F/U (followed upt. (patient) status an with diagnosis of AM acute cystitis (urinary). There was no evident the required informat hospital for Resident hospital transfers dated to receiving providers transferred to the hosusually give a face sidemographics, historsome labs [laborator have a transfer form documents that we smonths ago, however consistently." ASM # evidence that the recas but not limited to:	g a score of five on the BIMS ental status), indicating the cognitive impairment. al record revealed that she ital on 11/28/18. A nurse's at 3:31 p.m., documented and an unplanned transfer. ed of transfer." al record revealed that she ital on 1/5/19. Nurse's note p.m., documented "This up) with (name of hospital) on and noted resident admitted S (altered mental status) and y tract infection)." ace in the clinical record that the ition was provided to the #90's facility initiated the 11/28/18 and 1/5/18. accimately 11:18 a.m., an compared with ASM (administrative in Nurse Executive. ASM #2 uments the facility provides is when a resident is spital. ASM #2 replied, "We sheet with the resident's rey and physical and also y tests results]. We also with a list of required that the facility had quired documentation such Contact information of the	F	522			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y3OC11

Facility ID: VA0279

If continuation sheet Page 72 of 206



	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION 3	co	TE SURVEY MPLETED C 02/07/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 622	all special instruct care and compreh provided for Resid dated 11/28/18 and On 02/07/19 at apthe Executive, and AS Specialist, were made to the facility policy with a most recent documented, "5.3 and/or health care hospital with the made of the facility policy with a most recent documented, "5.3 and/or health care hospital with the made of the facility policy with a most recent documented, "5.3 and/or health care hospital with the made of the facility out of the facility out of the facility of the facilit	information, Advance Directive, ions or precautions for ongoing tensive care plan goals, was dent #90's hospital transfer and 1/5/18. ASM #2 replied, "No." oproximately 5:45 p.m., ASM #1, ector and ASM #2, the Nurse SM #3, Clinical Quality hade aware of the findings. Ititled "Discharge and Transfer" to revision date of 11/28/16 Patient's advance directives instructions will be sent to the esident." Interpolation was provided prior to exit. Imporary loss of consciousness. faint, you'll feel dizzy, auseous. Your field of vision may lose muscle control at the same of the down. This information was executed the same of the discount was executed to the same of	F 6			
	meta?v%3Aproject medlineplus-bund 3. The facility state all required information contact information ongoing care, additionally comprehensive contact the hospital staff.	m.nih.gov/vivisimo/cgi-bin/query- ct=medlineplus&v%3Asources= dle&query=syncope. If failed to provide evidence that nation (including physician on, resident representative on, special instructions for vance directives and are plan goals) was provided to when Resident #51 was hospital on 1/24/19.				

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
495246	B. WING	100	02/07/2019
ER	11 D	AIRY LANE	DE
FICIENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION DATE
was admitted to the facility on ent #51's diagnoses included but it to diabetes, high blood pressure as. Resident #51's most recent in data set), a 14 day Medicare the an ARD (assessment reference 18, coded the resident's cognition paired. Ident #51's clinical record revealed as transferred to the hospital on a fall. Further review of Resident ecord (including nurses' notes) evidence that the facility staff equired information to hospital staff ent was transferred. In EDN (licensed practical nurse) #3. sked to describe the information of the hospital. LPN #3 stated, usually go by their name, date of oning as to why we are sending ery, code status, last set of vitals, normal, face sheet, labs [laboratory item asked if the resident is contact information, physician's eation and special instructions for ited, LPN #3 stated that information on an elnteract form. LPN #3 eract form is sometimes but not ad to the hospital staff. LPN #3 eract form is provided via phone if the is not sent to the hospital. When ints' comprehensive care plan	F 622		
	IDENTIFICATION NUMBER:	A BUILDING 495246 B. WING IT DEPTIFICATION NUMBER: 495246 B. WING IT DEPTIFIES A STRICT OF DEFICIENCIES PROBLEM OF LICENCIES PROB	A BUILDING 495246 B. WING STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405 INTERIOR MUST BE PRECEDED BY FULL RRY OR LSC IDENTIFYING INFORMATION) In page 73 Was admitted to the facility on letent #51's diagnoses included but do diabetes, high blood pressure a. Resident #51's most recent n data set), a 14 day Medicare than ARD (assessment reference 18, coded the resident's cognition paired. Ident #51's clinical record revealed as transferred to the hospital on a fall. Further review of Resident ecord (including nurses' notes) evidence that the facility staff equired information to hospital staff ent was transferred. In PREFIX To a company to the provided was a company to the properties of th

PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		E SURVEY PLETED
		495246	B. WING		02	/07/2019
12,8112, 540	PROVIDER OR SUPPLIER ONT CENTER			STREET ADDRESS, CITY, STATE, ZIP C 11 DAIRY LANE FREDERICKSBURG, VA 22405	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 656 SS=E	evidence the informal hospital staff. LPN #3 goes but are not able off with a form that we envelope but it's new using it." Further review of Resi failed to reveal an elnt containing all the requirement on 2/6/19 at 5:39 p.m. member) #1 (the exect nurse executive) and #4 specialist) were made concern. No further information to Develop/Implement Co CFR(s): 483.21(b)(1) §483.21(b) Comprehent S483.21(b)(1) The facilism plement a comprehent care plan for each resident rights set forth s483.10(c)(3), that includes that are identified assessment. The comprehences that are identified in the second in the second in the resident in the	ion that is provided to a stated, "We know that stuff to evidence. They started a check off with, with an and I'm not sure everyone is dent #51's clinical record eract form or check off list ired information. ASM (administrative staff utive director), ASM #2 (the ISM #3 (the clinical quality awars of the above was presented prior to exit. Imprehensive Care Plan sive Care Plans they must develop and a sive person-centered ent, consistent with the at §483.10(c)(2) and des measurable es to meet a resident's ental and psychosocial in the comprehensive ehensive care plan must to be furnished to attain a highest practicable ychosocial well-being as §483.25 or §483.40; and ald otherwise be required	F 656	F656 1. Resident #50 care pla to address mail delive #52 care plan was cor include oxygen while present, Resident #97 was developed to add behavior of cursing, R care plan for call bell pwas not followed, Resident #309 care plan was developed to address feeding and to tube, Resident #309 care plan to address Resident #71 care plan respiratory medication implemented, Resident plan for pressure injur was implemented.	ery, Resident rected to surveyor was care plan ress resident esident #7 placement ident #99 ped to racheostomy are plan was oxygen, or for the was at #29 care	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y30C11

Facility ID: VA0279

f continuation sheet Page 75 of 206

MAR 0.8 2019 VDH/OLC

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION	COM	E SURVEY
3 8 1	NT CENTER		<i>e</i> - 1	STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405		2/07/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
fare fare fare fare fare fare fare fare	under §483.10, including treatment under §483 (iii) Any specialized size habilitative services provide as a result of recommendations. If indings of the PASAF rationale in the reside (iv) In consultation with resident's representate (A) The resident's good desired outcomes. (B) The resident's prefuture discharge. Facily whether the resident's prefuture discharge. Facily whether the resident's community was assessed at contact agencies entities, for this purpose (C) Discharge plans in colan, as appropriate, in equirements set forth rection. This REQUIREMENT (y): Based on resident interesident in the survey sample, Fernal (a) and for the survey sample, Fernal (a) and #20 (a) the facility staff faile	esident's exercise of rights ding the right to refuse 3.10(c)(6). ervices or specialized at the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the ive(s)-els for admission and derence and potential for lities must document desire to return to the sed and any referrals to end/or other appropriate se. If the comprehensive care in accordance with the in paragraph (c) of this is not met as evidenced erview, staff interview, w, and clinical record and that the facility staff enplement the an for eight of 55 residents Resident #50, #52, #97, #7, 19. dito develop a an regarding Resident	F	2. All residents in the frequiring mail deliver administration of ox displaying behaviors requiring proper call placement, requiring and tracheostomy carequiring respiratory medication and requires injury treat risk. Care Plans for caresidents with oxyge behaviors, tube feed tracheostomy and remedications were resupdated accordingly with specific / special needs have had their updated accordingly residents have been as having concerns where the mail that they received dangerous/hazardous. 3. Nurse Practice Educated designee to in-service nursing staff on care development and impositions.	ery, eygen, s of cursing, l bell g tube feed are, viring ment are at current en, ling, espiratory viewed and Residents l call bell r care plans No other identified vith the e as being s. tor, ADON or e licensed plan	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/22/2019 FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED 495246 B. WING 02/07/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE WOODMONT CENTER FREDERICKSBURG, VA 22405 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) Continued From page 76 F 656 **ADON, Nurse Practice Educator** F 656 oxygen for Resident #52. and or designee to audit 10 random care plans weekly for 4 3. The facility staff failed to develop a behavior weeks, then randomly thereafter care plan for Resident #97 to address the residents cursing. to ensure development and implementation occur. Variances 4. The facility staff failed to follow Resident # 7's will be corrected immediately and comprehensive care plan for the placement of the call bell. brought to Quality Assurance and Performance Improvement 5. The facility staff failed to develop a Committee monthly, with QAPI comprehensive care plan for Resident # 99's tube feeding and tracheostomy care. Committee responsible for ongoing compliance. 6. The facility staff failed to develop a 5. Date of Compliance: 3/15/19 comprehensive care plan for Resident # 309's oxygen. 7. The facility staff failed to implement Resident #71's care plan for respiratory medication administration. 8. The facility staff failed to implement Resident #29's care plan for pressure injury treatment. The findings include: 1. Resident #50 was admitted to the facility on 8/20/17. Diagnosis included but were not limited to: high blood pressure, depression, chronic obstructive pulmonary disease (1) and obstructive sleep apnea (2).

The most recent MDS (minimum data set), an annual assessment, with an assessment reference date of 7/24/18, coded the resident as having a score of 15 of 15 on the BIMS (brief interview for mental status) indicating the resident

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		TE SURVEY MPLETED
		495246	B. WING			2/07/2019
	PROVIDER OR SUPPLIER	*		STREET ADDRESS, CITY, STATE, ZIP C 11 DAIRY LANE FREDERICKSBURG, VA 22405		220112013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	was cognitively intaid On 02/05/19 at apprinterview was conducted Resident # 50 was a offered him privacy. The social worker of acility administration have a 'bum' should them to stretch my an about this, they said they opened my pack. The social worker no p.m., documented "(rotator cuff pain and the flexibility and pain #50) continues to ord amazon that might not facility (i.e. gym equip is aware that anything the reviewed first so the anything inappropriate. The comprehensive of 2019, failed to address this mail should be delected. On 2/6/19 at approximaterview was conducted.	ct to make daily decisions. roximately 11:09 a.m., an acted with Resident #50. asked if he felt the facility. Resident #50 replied "For the of months ago I was ackage in the mail but when it had opened it. I was pretty. I let the administration know lent #50 was asked what was ident #50 replied "Some I from Amazon. They (the in) thought it was a weapon. I ler, and I was going to use rms. After I complained they would ask me before kages." It dated 8/21/18 at 3:07 mame of Resident #50) has a goals will focus on improving in level. (Name of Resident ler equipment of (sic) on the appropriate for our orment, karate gear, etc.). He go he wants to order should not he does not bring the to the facility." Pare plan dated February is how Resident #50's appropriate items and how ivered.	F 656			
		CNA #1 was asked what plan is. CNA #1 replied, "It				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN B. WING	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C 02/07/2019
AND PLAN OF CORRECTION A95246 NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 656 Continued From page 78 contains all the basic information about how to care for a resident." On 02/07/19 at approximately 8:52 a.m., an interview was conducted with ASM (administrative staff member) #1, the Executive Director. ASM #1 was asked if any residents had complained of getting opened mail. ASM #1 replied, "Yes (name of Resident #50), told me while I made a tour, that a while back before I got here, he had received an opened package. The resident had a history of getting weapons in the mail, so the previous administrator opened his package. However when I found out about this I educated the staff on not opening a residents mail. We also told him that he can't have any weapons here. And now staff are not to open any of his package unless he consents and they open it in his presence." On 2/7/19 at approximately 11:27 a.m., an	ISC(Press SA	STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405			
PREFIX	(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (ENCY)	ULD BE COMPLETION
F 656	contains all the bacare for a resident On 02/07/19 at apinterview was constaff member) #1, was asked if any getting opened mof Resident #50), that a while back received an openhistory of getting previous administ However when I fithe staff on not optold him that he cand now staff are unless he consent	proximately 8:52 a.m., an ducted with ASM (administrative the Executive Director. ASM #1 residents had complained of ail. ASM #1 replied, "Yes (name told me while I made a tour, before I got here, he had ed package. The resident had a weapons in the mail, so the rator opened his package. found out about this I educated bening a residents mail. We also an't have any weapons here.	F 6	56	
	interview was cornurse) #5, Nurse asked if Resident how his mail shou "No." RN #5 was plan should incluinappropriate iter to handle his mail On 2/7/18 at app (administrative st Director and ASM ASM #3, Clinical aware of the find	roducted with RN (registered Practice Educator. RN #5 was a #50's care plan documented all be delivered. RN #5 replied, asked if Resident #50's care de his history of ordering ms, and if it should address how il. RN #5 replied, "Yes." roximately 5:45 p.m., ASM taff member) #1, the Executive M #2, the Nurse Executive, and Quality Specialist, were made			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	riple construction NG	(X	OMPLETED
		495246	B. WING_			02/07/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 656	can lead to shortness types are chronic brown the main cause of to substances that in This is usually cigarichemical fumes, or information was obtainties://www.nlm.nih. 2. Obstructive sleep which your breathing occurs because of mathematical fumes. This information was https://medlineplus.s/ 2. The facility staff #52's comprehensive administration of ox Resident #52 was a 2/7/2013. Diagnose limited to: chronic of (COPD) (1), myelod anemia (3), depressibility. The most recent Mathematical forms a having a score of (brief interview for mathematical forms a score of (brief interview for mathematical forms and countered that Retherapy.	es it difficult to breath that is of breath). The two main conchitis and emphysema. COPD is long-term exposure tritate and damage the lungs. The ette smoke. Air pollution, dust can also cause it. This sained from the website: gov/medlineplus/copd.html. To apnea (OSA) is a problem in g pauses during sleep. This harrowed or blocked airways. Is obtained from the website: gov/ency/article/000811.htm.	F	656		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	27 1074-02.10-01	E CONSTRUCTION	co	TE SURVEY MPLETED C 02/07/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405		7210172013	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF O (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 656	Continued From pa	age 80	F 65	6			
	nasal cannula (a p inserts in the nose The comprehensiv	gen at 2 liters per minute via lastic tube with two prongs that continuously." e care plan dated 7/13/18 (oxygen) as ordered."					
	On 2/5/19 at appro observation was m #52 was observed cannula connect to Observation of the oxygen concentraterate was set with the	eximately 8:34 a.m., an nade of Resident #52. Resident receiving oxygen via a nasal or an oxygen concentrator. flow meter on Resident #52's or revealed the oxygen flow the ball between the 2.0L/min and 2.5L/min lines.					
	On 2/5/19 at appro observation was m concentrator. Observations #52's oxy oxygen flow rate w	eximately 3:30 p.m., a second nade of Resident #52's oxygen ervation of the flow meter on a concentrator revealed the vas set with the ball between a per minute) and 2.5L/min					
	observation was moxygen concentrat (licensed practical to read the flow moconcentrator. After oxygen concentration its set at 2.5L (liter on 2/5/19 at approximate the content of the cont	oximately 3:41 p.m., an					
	asked was asked	ducted with LPN #1. When how an oxygen flow meter is led, "The top of the ball is a the line."		w w			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	
		495246	B. WNG _		02/07/2019	
	D PLAN OF CORRECTION IDENTIFICATION NUMBER:			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405		
PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 656	Continued From pag	e 81	F 6	56		
	interview was condu nurse) #2. RN #2 wa oxygen flow meter is	cted with RN (registered is asked how the rate on an set. RN #2 replied, "You turn				
<i>a</i>	interview was condu nursing assistant) #* care plan. CNA #1 rd information about ho CNA #1 was asked it	cted with CNA (certified I, regarding the purpose of a eplied, "It's all the basic ow to care for a resident." residents' care plans should	÷.			
	interview was condupractical nurse) #2. purpose of resident has all the information for a particular resident #52's care	cted with LPN (licensed LPN #2 was asked the care plans. LPN #2 replied, "It on you need so you can care ent." LPN #2 was asked if plan in regards to oxygen				
	(administrative staff Director and ASM # ASM #3, Clinical Qu	member) #1, the Executive 2, the Nurse Executive, and ality Specialist, were made				
	No further information	on was provided prior to exit.				
	can lead to shortness types are chronic by The main cause of to substances that in This is usually cigar chemical fumes, or					

+	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	CC	ATE SURVEY DMPLETED C	
	ROVIDER OR SUPPLIER	495246 B. WING		STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405		02/07/2019	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 656	2. Your bone marror some of your bones bones. It contains in cells. The stem cells blood cells that carry the white blood cells platelets that help w a myelodysplastic synot mature into heal die in the bone marr not have enough he infection, anemia, or information was obtained.	ge 82 gov/medlineplus/copd.html. w is the spongy tissue inside such as your hip and thigh mature cells, called stem can develop into the red y oxygen through your body, that fight infections, and the ith blood clotting. If you have yndrome, the stem cells do thy blood cells. Many of them ow. This means that you do althy cells, which can lead to reasy bleeding. This ained from the website: gov/myelodysplasticsyndrome	F 65	6			
	3. If you have anemenough oxygen to the common cause of a iron. Your body need Hemoglobin is an iron red color to blood. It lungs to the rest of the obtained from the white hemoglobin is an iron red color to blood. It lungs to the rest of the obtained from the white hemoglobin is an iron red color to blood. It lungs to the rest of the obtained from the white hemoglobin is an iron red color to blood. It lungs to the rest of the obtained from the white hemoglobin is an iron red color to blood. It lungs to the rest of the color to the	nia, your blood does not carry ne rest of your body. The most nemia is not having enough ds iron to make hemoglobin. on-rich protein that gives the carries oxygen from the he body. This information was ebsite: nih.gov/vivisimo/cgi-bin/query- medlineplus&v%3Asources= &query=anemia&_ga=2.7128 542638661-1154288035.154 failed to develop a behavior ent #97 to address the dmitted to the facility on oses that included but were					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN B. WING _	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C 02/07/2019	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
F 656	hemiplegia (1) and cerebral infarction (minimum data set) assessment, with a date) of 1/18/19 co scored a 15 out of for mental status) in cognitively intact to resident was coded assistance with eat On 02/05/19 at approbservation was coroom, where lunch #97 was observed continuously at state complaining to other about the food and On 02/05/19 at appropersion of the survey does this, and they something." On 02/05/19 at appropersion of 02/05/19 at appropersion was coroom, where lunch about the food and On 02/05/19 at appropersion of 02/05/19 at appropersion	etes, high blood pressure, hemiparesis (2) following (3). The most recent MDS (3). The most recent MDS (4), a Medicare thirty day in ARD (assessment reference ded the resident as having 15 on the BIMS (brief interview indicating the resident was make daily decisions. The das requiring limited ting. Proximately 12:20 p.m., an onducted in the main dining was being served. Resident cursing loudly and ff. He was also observed for residents in the dining hall service in the lunchroom. Proximately 12:22 p.m., esident #97, "Can you please guage." Resident #8 then eyor and stated, "He always of the facility staff) need to do proximately 12:32 p.m., Resident #97, "Watch your However, Resident #97	F6	56		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED C 02/07/2019	
	ROVIDER OR SUPPLIER	495246	STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 656	room." On 02/06/19 at app interview was cond was asked if Reside in the dining room. known for cursing was asked about the plans. CNA #1 replinformation about h CNA #1 was asked cursing in the dining care plan, CNA #1 asked how all staff Resident #97 in reg	ge 84 of language in the dining roximately 1:47 p.m., an ucted with CNA #1. CNA #1 ent #97 had a habit of cursing CNA #1 replied, "Yes, he is we have told him in the past to the does not listen." CNA #1 the purpose of resident care tied, "It contains all the basic tow to care for a resident." if Resident #97's behavior of the groom was addressed in his replied "No." CNA #1 was would know how to care for teards to his behavior, if they with him. CNA #1 replied, "If	F 656			
	in his chart, I don't On 02/07/19 at apprinterview was cond nurse) #5, Nurse P asked about the purity RN #5 replied, "It cabout how to care in should that be a part RN #5 replied, "Yes Review of Residen 12/24/18 and revised document the residuling room. On 02/07/19 at apprinter apprinter in the purity of the state of the purity of the state of the purity of the p	proximately 11:27 a.m., an ucted with RN (registered ractice Educator. RN #5 was prose of residents' care plans, communicates with all staff for a specific resident's needs." If a resident has behaviors; rt of the residents care plan,				

PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

AND DI AN OF CODDICTION		1`'	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		495246	B. WNG			I	07/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	aware of the findings	ality Specialist, were made	F	656			
	to exit. 1. Also called: Hem and Quadriplegia. Function in part of your something goes wro pass between your becan be complete or both sides of your become area, or it can be information was obtantips://medlineplus.go	iplegia, Palsy, Paraplegia, Paralysis is the loss of muscle our body. It happens when any with the way messages orain and muscles. Paralysis partial. It can occur on one or ody. It can also occur in just e widespread. This pained from the website: gov/paralysis.html.					
	brain stops. A stroke attack." If blood flow few seconds, the broxygen. Brain cells damage. This inform website: https://medlineplus. 2. Bradycardia is a stroke hearts of adults 60 and 100 times a bradycardia (bradebeats fewer than 60 can be a serious propump enough oxygen.	blood flow to a part of the e is sometimes called a "brain w is cut off for longer than a ain cannot get nutrients and can die, causing lasting nation was obtained from the gov/ency/article/000726.htm. slower than normal heart rate. e at rest usually beat between minute. If you haveKAHR-dee-uh), your heart times a minute. Bradycardia beliem if the heart doesn't en-rich blood to the body. For ver, bradycardia doesn't					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y30C11

Facility ID: VA0279

If continuation sheet Page 86 of 206



STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	LE CONSTRUCTION	(X3)	(X3) DATE SURVEY COMPLETED		
		495246	B. WING			C	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 656	information was obth https://www.mayocl adycardia/symptom 4. The facility staff comprehensive cardial bell. Resident # 7 was an 10/12/17 with diagram not limited to lack on arthritis (1), Alzhein gastroesophageal in hypertension (4). Resident # 7's moss set), an annual assing (assessment reference Resident # 7 as section for making 7 was coded as reconstaff member for Section G0400 "Fur Motion" coded Resident # 7 reveal awake, neat and clean and clean additional codes and	complications. This rained from the website: inic.org/diseases-conditions/br s-causes/syc-20355474?p=1 failed to follow Resident # 7's e plan for the placement of the disease that included but were for coordination, rheumatoid ner's disease (2), eflux disease (3) and trecent MDS (minimum data essment with an ARD nice date) of 10/20/18, coded oring an eight on the brief lestatus (BIMS) of a score of 0 moderately impaired of godaily decisions. Resident # puring extensive assistance of or activities of daily living. Inctional Limitation in Range of ident # 7 as being impaired on oper extremities (shoulder, 28 a.m., an observation of led she was lying in bed, ean, watching television. The	F 65	6			
	was under the upper Further observation was leaning toward the call bell reveale	s slightly raised and a pillow er part of Resident # 7's back. n of Resident # 7 revealed she her left side. Observation of ed it was a flat pressure switch. call bell's placement revealed		22			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246		A. BUILDII	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED C		
		495246	D. VVIING	STREET ADDRESS, CITY, STATE, ZIP CODE	02/07/2019	
	ROVIDER OR SUPPLIER			11 DAIRY LANE FREDERICKSBURG, VA 22405	•	
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE COMPLETION	
F 656	right corner, behind asked if she could lo 7 moved her head s left and struggled to under the blanket co stated, "I don't know Resident # 7's moved decreased range of On 02/05/19 at 3:22 Resident # 7 reveals awake, neat and cle head of the bed was was under the uppe Further observation was leaning slightly of the call bell's place hanging off the side right corner, behind	The mattress in the upper Resident # 7's head. When cate the call bell Resident # lightly to the right and then remove her right arm from evering her. Resident # 7 where it is." Observation of ements revealed there was motion. p.m., an observation of ed she was lying in bed, ean, watching television. The es slightly raised and a pillow or part of Resident # 7's back. of Resident # 7 revealed she to her left side. Observation ement revealed it was of the mattress in the upper Resident # 7's head. When coate the call bell Resident #	F	656		
	On 02/06/19 at 8:01 Resident # 7 was ly clean, watching tele was slightly raised a upper part of Resident observation of Residening slightly to he call bell's placement bed, on Resident # shoulder. When as bell Resident # 7 st On 02/07/19 at 8:18 Resident # 7 was ly clean, watching tele	a.m., an observation of ing in bed, awake, neat and evision. The head of the bed and a pillow was under the ent # 7's back. Further dent # 7 revealed she was er left side. Observation of the t revealed it was lying on the 7's right side just below her ked if she could locate the call ated, "I don't know where it is." 5 a.m., an observation of ring in bed, awake, neat and evision. The head of the bed and a pillow was under the				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246		(X2) MULTIPL A. BUILDING B. WING	LE CONSTRUCTION		SURVEY LETED · 07/2019		
	NOVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	observation of Resideaning slightly to he call bell's placement bed, on Resident # shoulder. When as bell Resident # 7 states to the comprehensive dated 10/25/2017 w 12/12/2018 documerisk for falls related of safety awareness initiated 10/25/2017 Under "Intervention light within reach with to the bed. Date initiated 10/26/19 at 1:47 conducted with CN/1" When asked to care plan, CNA # 1 information about h When asked if they care plans, CNA # 1 tablet." On 02/06/19 at 2:17 conducted with LPN 2. When asked to care sked to care plans, CNA # 1 tablet."	ent # 7's back. Further dent # 7 revealed she was er left side. Observation of the t revealed it was lying on the 7's right side just below her ked if she could locate the call ated, "No." care plan for Resident # 7 with a revision date of ented, "Focus. Resident is at to cognitive impairment, lack a and impaired mobility. Date 7. Revision date: 12/12/2018." s", it documented Place call hile in bed or close proximity	F 65	6			
	On 02/07/19 at 8:18 Resident # 7's call I with CNA (certified asked if the call bel Resident # 7 could	o for a particular resident." 5 a.m., an observation of bell placement was conducted nursing assistant) # 2. When I was placed in a position that reach and activate, CNA #2 ach, and she has limited					

STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION		TE SURVEY MPLETED C		
		495246	B. WING	· In a · · · ·	0	2/07/2019		
	ROVIDER OR SUPPLIER		11 D/	STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405				
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 656	range of motion." On 02/07/19 at 8:30 Resident # 7's call b with RN (registered of the call of the ca	a.m., an observation of ell placement was conducted nurse) # 8, unit manager. all bell was placed in a nt # 7 could reach and ed, "No" and immediately bell within reach of Resident 7 a.m., an interview was (registered nurse) # 5. When the purpose of the care plan, immunicate with all staff about ent, its updated constantly as change." Example 1 and 1 and 1 and 2 and 2 and 3	F 656					

the state of the s		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII B. WING	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C 02/07/2019		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CI 11 DAIRY LANE FREDERICKSBUR	ITY, STATE, ZIP CODE		7072013	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	(EACH C	VIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOU EFERENCED TO THE APPRO DEFICIENCY)	LO BE	(X5) COMPLETION DATE	
F 656	progressive brain of memory and thinking ability to carry out most common cause. While dementia is older, it is not a no information was other hittps://www.nia.nif. (4) High blood presobtained from the https://www.nlm.niessure.html. 5. The facility staft comprehensive casteeding and trached Resident # 99 was 01/09/19 with diagnot limited to apha (2), hemiplegia (3) (4). Resident # 99's mest), an admission (assessment references interview for mentical to the progression of the prog	ease is an irreversible, disorder that slowly destroys on skills and, eventually, the stee of dementia in older adults. It is the see of dementia in older adults. It is more common as people grow ormal part of aging. This obtained from the website: on.gov/health/alzheimers/basics. It is information was website: on.gov/medlineplus/highbloodpr If failed to develop a ore plan for Resident # 99's tube eleostomy care. If admitted to the facility on oneses that included but were onesia (1), tracheostomy status and cerebral vascular disease of the control of the priefical status (BIMS) of a score of 0 of severely impaired of cognition ecisions. Resident # 99 was tally dependent of two staff	F	556	DEFICIENCY			
1	"Swallowing/Nutrit 99 as having a fee Special Treatment	ities of daily living. Section K ional Status" coded Resident # eding tube. Under section "O. , Procedures and Programs", s coded as requiring		8	×			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C					
		495246	B. WING_		02/07/2019				
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405					
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE)				HOULD BE COMPLETION
F 656	Resident # 99 reveathe head of the bed television playing. FResident # 99 had a receiving humidification was infusing at 55m automatic flush and bedside table. The POS (physician 99 dated 02/01/19 d TUBE FEEDING, Trunder "Enteral Prote (5) 1.5 at 55ML/HR HRS (hours) continuit documented, "Character with the comp Resident # 99 dated date of 01/29/2019 documentation for the feeding. On 02/06/19 at 1:47 conducted with CN/41" When asked to care plan, CNA # 1 information about he When asked if they care plans CNA # 1 tablet." On 02/06/19 at 2:17	a.m., an observation of led she was lying in bed, with slightly raised and her further observation revealed tracheostomy and was tion by a tube, a tube feeding illiliters per hour with an a suctioning machine was on order sheet) for Resident # ocumented, "Diagnosis: RACH (tracheostomy)." ocols" it documented, "Nutren (milliliter per hour) x (times 24 tously." Under "Treatments" ange trach collar every day." orehensive care plan for 101/10/2019 and a revision failed to evidence racheostomy care and tube of p.m., an interview was a (certified nursing assistant) # describe the purpose of the stated, "All the basic ow to care for a resident." had access to the resident's stated, "Yes, it's on our	F	656					
	2. When asked to d	I, (licensed practical nurse) # describe the purpose of the stated, "It has all you need so							

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495246	(X2) MULTIF A. BUILDING B. WING	PLE CONSTRUCTION 3	COM	E SURVEY MPLETED C 2/07/2019				
	NT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405						
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL P		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACT		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 656	On 02/06/19 at 2:5 conducted with RN coordinator and LF 6, MDS nurse. Aff care plan for trach # 6 and LPN # 6 sasked to describe RN # 6 stated, "W look at diagnosis to care plan. When the CAA (care a make sure that the When I do the upd whatever is trigger On 02/07/19 at 11 conducted with RN asked to describe RN # 5 stated, "Cothe needs of a residents need On 02/07/19 at ap (administrative states)."	do for a particular resident." 3 p.m., an interview was I (registered nurse) # 6, MDS IV (licensed practical nurse) # er Reviewing Resident # 99's eostomy and tube feeding, RN tated, "It's not there." When the process for the care plan, nen a resident is admitted we nen that ends up on the interim he MDS is completed we look rea assessment) triggers we see areas are on the care plan. ates I look at the CAA and red I add to the care plan." 27 a.m., an interview was I (registered nurse) # 5. When the purpose of the care plan, ommunicate with all staff about ident, its updated constantly as	F 65	56						
	made aware of the									
	the brain that cont hard for you to rea mean to say) This the website:	sed by damage to the parts of rol language. It can make it id, write, and say what you information was obtained from ih.gov/medlineplus/aphasia.htm								

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN 495246 B. WING _		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 02/07/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 11 DAIRY LANE FREDERICKSBURG, VA 22405	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLETION BE APPROPRIATE DATE
F 656	(2) A surgical proceet through the neck int tube is most often p provide an airway at the lungs. This tube or trach tube. This is the website: https://medlineplus.(3) Also called: Hen Quadriplegia. Paralfunction in part of your something goes wro pass between your can be complete or both sides of your bone area, or it can be information was obthttps://medlineplus. (4) A stroke. When brain stops. A strok attack." If blood flow seconds, the broxygen. Brain cells damage. This inform website: https://medlineplus. (5) Calorically-dens tube-feeding formulation was obthtps://www.nestlet/nutren-1-5-hcp.	dure to create an opening to the trachea (windpipe). A laced through this opening to and to remove secretions from is called a tracheostomy tube information was obtained from gov/ency/article/002955.htm. Iniplegia, Palsy, Paraplegia, lysis is the loss of muscle our body. It happens when ong with the way messages brain and muscles. Paralysis partial. It can occur on one or ody. It can also occur in just be widespread. This ained from the website: gov/paralysis.html. Iblood flow to a part of the e is sometimes called a "brain w is cut off for longer than a rain cannot get nutrients and can die, causing lasting mation was obtained from the gov/ency/article/000726.htm. In a for increased energy or restricted fluid volume. This tained from the website: nealthscience.us/brands/nutren	F 65	56	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (CONSTRUCTION		(X3) DATE SURVEY COMPLETED C							
		495246	B. WING		0:	2/07/2019						
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405									
(X4) fD PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 656	01/23/2019 with dia not limited to: edem hypertension (3) an Resident # 309's m data set), an admis (assessment refere Resident # 309 as s interview for menta - 15, 15 - being cog	s admitted to the facility on gnoses that included but were a (1), respiratory failure (2),	F 656									
	requiring limited as for activities of daily Special Treatment, Resident # 309 was therapy." On 02/05/19 at 9:44 Resident 309 reveal receiving oxygen by an oxygen concent Observation of the concentrator reveal.	sistance of one staff member vilving. Under section "O. Procedures and Programs" s coded for "C. Oxygen 5 a.m., an observation of aled she was lying in her bed y nasal cannula connected to rator that was running. flow meter on the oxygen led an oxygen flow rate -a-half liters and four liters per										
	The POS (physicia 309 dated "01/23 2	n's order sheet) for Resident # 019"documented, "O2 o liters) via (by) N/C (nasal s."										
	The comprehensive dated 01/25/2019 f documentation for											
	On 02/06/19 at 1:4	7 p.m., an interview was										

PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DINSTRUCTION	(X3) DATE SURVEY COMPLETED	
		8% ¥	A. BOICD			0	,
		495246	B. WNG			02/0	07/2019
	ROVIDER OR SUPPLIER		····	11 D	EET ADDRESS, CITY, STATE, ZIP CODE AIRY LANE DERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 656	conducted with CNA 1 " When asked to de care plan, CNA # 1 s information about how When asked if they hear plans, CNA # 1 tablet." On 02/06/19 at 2:17 conducted with LPN, 2. When asked to de care plan, LPN # 2 s you know what to do On 02/06/19 at 2:53 conducted with RN (coordinator and LPN 6, MDS nurse. After care plan for oxygen "It's not there." Whe process for the care a resident is admitted that ends up on the impose sessment) triggers	(certified nursing assistant) # escribe the purpose of the	F	656	DEFICIENCY)		
		CAA and whatever is					
	conducted with RN (asked to describe th RN # 5 stated, "Com the needs of a reside the residents needs	7 a.m., an interview was registered nurse) # 5. When e purpose of the care plan, imunicate with all staff about ent, its updated constantly as change."					
	(administrative staff	member) #1, the executive 2, executive nurse, were		4			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y30C11

Facility ID: VA0279

If continuation sheet Page 96 of 206



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495246	B. WNG	a de la company de la comp	C 02/07/2019		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO		SHOULD BE COMPLETION		
F 656	Continued From pag made aware of the a		F 656				
	Reference: (1) A swelling cause tissues. This inform website: https://www.nlm.nih.	d by fluid in your body's ation was obtained from the gov/medlineplus/edema.html.					
	lungs into your blood obtained from the w https://www.nlm.nih. ilure.html.	gov/medlineplus/respiratoryfa					
	obtained from the w	sure. This information was ebsite: .gov/medlineplus/highbloodpr					
	website:	mation was obtained from the .gov/medlineplus/anxiety.html					
		ailed to implement Resident respiratory medication		= 1			
	10/1/18. Resident # were not limited to disease (2), low bad Resident #71's mos set), a quarterly ass	idmitted to the facility on 471's diagnoses included but chronic obstructive pulmonary ck pain and anxiety disorder. It recent MDS (minimum data lessment with an ARD nice date) of 1/8/19, coded the orginitively intact.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED C	
		495246	B. WNG		02/07/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 656	Continued From pag	ge 97	F 6	56	8	
	a physician's order of	#71's clinical record revealed dated 10/17/18, for Advair 500 0 mcg and to inhale one puff		Si di		
	January 2019 MARs records) failed to reto the resident (as ewith no documented following dates and 11/1/18 at 9:00 p.n 11/3/18 at 9:00 p.n 11/3/19 at 9:00 p.m 1/23/19 at 9:00 p.m 1/23/19 at 9:00 p.m	n., n., .m., n. n. ose dates failed to reveal the				
	MAR revealed Advaresident on the follo-1/6/19 at 9:00 a.m1/18/19 at 9:00 a.n1/19/19 at 9:00 a.n1/29/19 at 9:	n. and 9:00 p.m., n. and m. eve, the nurses circled their ented the medication was not ck of the MAR. eprehensive care plan dated d, "Resident exhibits or is at complications related to				
	On 2/5/19 at 12:20 conducted with Res	edicate as ordered" p.m., an interview was sident #71. The resident getting his Advair as he was				

the same sales	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495246	B. WNG		C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405	02/07/2019
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION
F 656	Continued From pag supposed to "for a w "straightened itself o	hile" but that had	F 656	3	
	conducted with LPN LPN #3 was asked to LPN #3 stated, "So how to really care for require any equipment asked how nurses eresidents' care plans most, they honestly physician orders, an administration record confirmed residents nurses need to reviet how nurses evident treatments they administration and TAR." In there are blank spart the nurses did not sometiments in their initials on the first in contained (Immediate) box (a medications that caresident if needed), contained in the fact provided by that phyvarious medications each resident). LPI process for ensuring administration, if no	m., an interview was (licensed practical nurse) #3. the purpose of a care plan. the nursing staff can know or the resident and if they ent or anything really." When ensure they implement s, LPN #3 stated, "Usually go by the orders; the ad their MARs (medication ds) and stuff." LPN #3 care plans are available if ew them. LPN #3 was asked the medications and minister. LPN #3 stated, "They (medication administration When asked what is meant if ces on the MAR, or TAR and ign off, LPN #3 stated, "In they didn't do it." LPN #3 meant if nurses sign and circle MAR. LPN #3 stated, "Usually I, either they held it, or are supposed to explain on R." LPN #3 was asked if in the facility STAT box containing various in be accessed for any LPN #3 stated Advair is ility omnicell (a machine armacy, containing many is that can be accessed for N #3 was asked the facility g Advair is available for t in the medication cart. LPN in check the omnicell. If it's			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION AND IMPED		NG	(X3) DATE SURVEY COMPLETED C
		495246	B. WING_		02/07/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 11 DAIRY LANE FREDERICKSBURG, VA 22405	
(X4) ID PREFIX TAG	(EACH DEFICIEN		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETION DATE
F 656	AG REGULATORY OR LSC IDENTIFYING INFORMATION)		F	356	
	#29's care plan for Resident #29 was a 8/11/18. Resident if were not limited to and abnormal postu- recent MDS (minim Medicare assessment reference date) of a cognition as moder coded Resident #25	railed to implement Resident pressure injury treatment. admitted to the facility on #29's diagnoses included but urinary tract infection, arthritis ure. Resident #29's most um data set), a 30 day ent with an ARD (assessment I1/21/18, coded the resident's ately impaired. Section G 9 as requiring extensive staff with bed mobility, toilet			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 495246	(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION	СОМ	E SURVEY PLETED C 1/07/2019
	NT CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405	· · · · · · · · · · · · · · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	Resident #29 as hinjury (1) that was Review of a skin in revealed Resident three-pressure inju. 10/29/18 document (left) buttock (with) prep to wound edg cover (with) dry dru (as needed) (illegit) Review of Resider November 2018 To records) failed to retreatment ordered Resident #29 on 1 11/11/18, 11/12/18 uns evidenced by nurses' initials were treatment had been urses' notes for the Resident #29's preadministered excedocumented treatment ordered. Resident #29's continued to the resident #29's continued	avigiene. Section M coded aving one stage three-pressure present upon admission. Itegrity report dated 10/29/18 #29 presented with a stage ary. A physician's order dated ated, "Cleanse open area L NS (normal saline), apply skin es, santyl (2) to wound bed & essing QD (every day) & PRN ole word)." It #29's October 2018 and ARs (treatment administration eveal evidence that the on 10/29/18 was provided for 0/30/18, 11/4/18, 11/25/18, 11/26/18, 11/29/18 and 11/30/18. This blank spaces on the TARs. No e signed off to indicate the n performed. Review of the above dates failed to reveal essure injury treatment was perfor a note dated 11/4/18 that ments were administered as actual skin to limited mobility, stage 3 eleft buttockProvide wound red"	F 65	6		
	conducted with LP LPN #3 was asked	p.m., an interview was N (licensed practical nurse) #3. If the purpose of a care plan. If the nursing staff can know				

PRINTED: 02/22/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		495246	B. WING			02/0	7/2019
NAME OF PROVIDER OR SUPPLIER WOODMONT CENTER				1	TREET ADDRESS, CITY, STATE, ZIP CODE 1 DAIRY LANE REDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	require any equipme asked how nurses er residents' care plans most, they honestly go physician orders, and administration record confirmed residents' nurses need to revie how nurses evidence treatments they admisign off on the MAR what is meant if there MAR, or TAR and the #3 stated, "In reality it." On 2/6/19 at 5:39 p.r member) #1 (the exenurse executive) and specialist) were made concern. No further information (1) "Pressure Injury: A pressure injury is and underlying soft to prominence or related device. The injury capen ulcer and may as a result of intense or pressure in combit tolerance of soft tiss may also be affected perfusion, co-morbid tissue. Stage 3 Pressure Injury:	the resident and if they nt or anything really." When nsure they implement , LPN #3 stated, "Usually	F	656			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y3OC11

Facility ID: VA0279

If continuation sheet Page 102 of 206



	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION		E SURVEY PLETED
		495246	B. WING		02	/07/2019
Sec. 174-174	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11 DAIRY LANE FREDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 656	is visible in the ulce epibole (rolled wou Slough and/or esch of tissue damage viareas of significant wounds. Undermin Fascia, muscle, ten and/or bone are no obscures the exten Unstageable Press was obtained from http://www.npuap.oclinical-resources/n (2) "SANTYL Ointroprescription medicing from wounds so the information was obth https://www.santyl.ccare Plan Timing at CFR(s): 483.21(b)(2) A corbe- (i) Developed within the comprehensive (ii) Prepared by an includes but is not lie (A) The attending plant includes but is not lie (A) The attending plant includes but is not lie (A) The attending plant includes but is not lie (B) A registered nurresident. (C) A nurse aide wit resident. (D) A member of for (E) To the extent prother resident and the	er and granulation tissue and and edges) are often present. For any be visible. The depth aries by anatomical location; adiposity can develop deep and tunneling may occur. Indon, ligament, cartilage at exposed. If slough or eschar at of tissue loss this is an ure Injury." This information the website: Ingresources/educational-and-puap-pressure-injury-stages/ I san FDA-approved the that removes dead tissue by can start to heal. "This is an index to heal." This is an ethat removes dead tissue by can start to heal. "This is an index from the website: I the com/ Ind Revision I days after completion of assessment. Interdisciplinary team, that imited to	F 65			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
- XXV		405246	B, WING		0.2	C
NAME OF S	PROVIDER OR SUPPLIER	495246	137 1 1 1	TREET ADDRESS, CITY, STATE, ZIP CO		/07/2019
	ONT CENTER		1	1 DAIRY LANE REDERICKSBURG, VA 22405		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 657	medical record if the and their resident renot practicable for the resident's care plan (F) Other appropriate disciplines as determined the analyses and assessments. This REQUIREMENT by: Based on staff interview, and clinical determined that the and/or revise the cout of 55 residents it Residents #39, #31, 1. The facility staff it Resident #39's compreviewed and/or reviewed and	e participation of the resident epresentative is determined he development of the	F 657	2. All residents in the falls, oxygen the catheter, and go for leave of absence visith 100% of current resident who catheter for Oxygen with the care current resident who current resident who current resident who current resident who catheter for the last 30 days were ensure that the care updated accordingly, residents that sign the on Leaves of Absence reviewed to ensure the plan addresses this according to the control of the control of the catheter for the catheter for the last 30 days were ensure that the care updated accordingly, residents that sign the on Leaves of Absence reviewed to ensure the plan addresses this according to the catheter for the cathete	erapy, Foley unsupervised ts are at risk. dents with ere reviewed s updated eview of all have had an discontinued in e reviewed to plan was All current emselves out e were hat their care	